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1945—1946

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THE RT. HON. LORD HORDER  
G.C.V.O., M.D., B.Sc., F.R.C.P.



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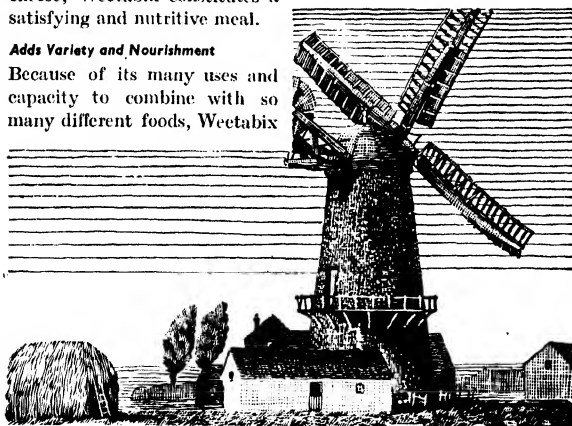
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<sup>1</sup> *A System of Air Purification by Hypochlorous Acid Gas*, 1938.

<sup>2</sup> *Recommendations of Lord Horder's Committee*.  
H.M. Stationery Office, Cmd. 6234, 1940.

<sup>3</sup> “The Problem of Air Borne Infection.”  
*Edinburgh Medical Journal*, Oct., 1942.  
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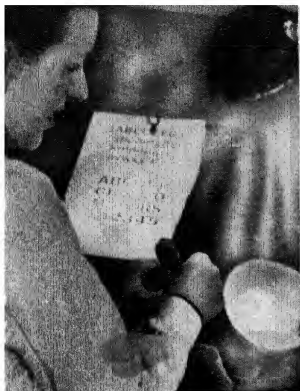
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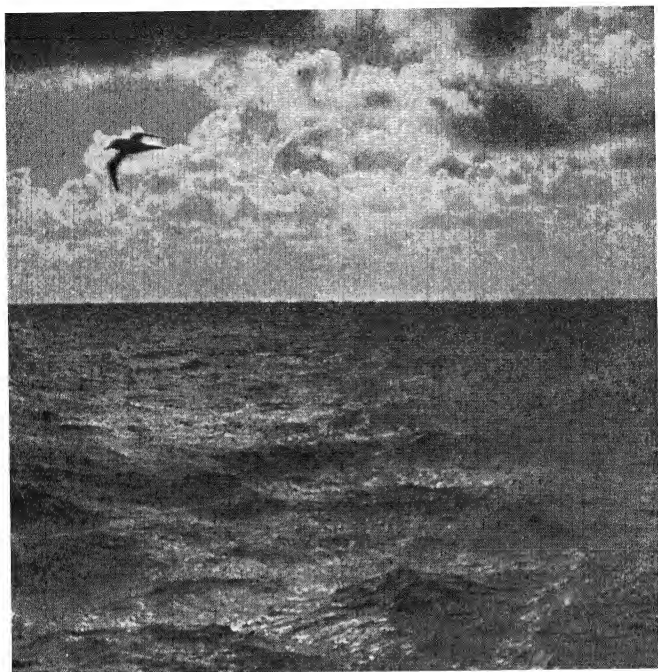
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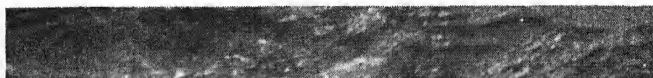
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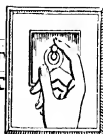
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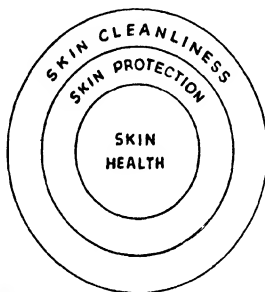
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The Joint Council of Qualified Opticians, founded in 1923, is a body to which membership is open to optical practitioners holding approved qualifications. All members enter into an agreement to observe the rules and regulations and the strict ethical code of the organisation.

Among its activities may be mentioned the following:—

(1) *It maintains a special department which acts as a liaison between Approved Societies and optical practitioners in connection with the administration of ophthalmic benefit under the N.H.I. Acts.*

(2) *The J.C.Q.O. is, in addition, responsible to the Joint War Emergency Committee (Optical Profession) for similar liaison duties between the optical profession and many Government departments in connection with Government Industrial Schemes.*

(3) *Ten years ago the J.C.Q.O. inaugurated a Visual Welfare Scheme for use in factories, whereby special arrangements are made either for the attendance of optical practitioners at factories for eye examination or for workers to be examined at practitioners' consulting rooms. The scheme gives priority in supply of appliances of standard quality and at standard charges. This scheme, used in many factories throughout the country, has been adopted by the Ministry of Supply. It is applicable to either large or small factories.*

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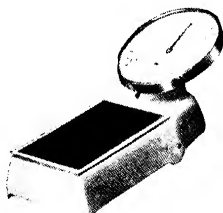
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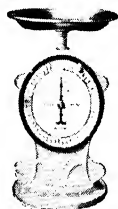
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## PUBLISHERS' FOREWORD

THE publishers present this, the second edition of *Health and Social Welfare*, at a time when most plans for the future have been thrown into the melting-pot by the General Election. It cannot be expected that the position will be wholly clarified for some time to come and it has, therefore been decided to publish now and to bridge the gap with a Supplement giving the latest available details. This will be found immediately preceding the Detailed Index on page 493.

The original contents have been completely revised and brought up-to-date and a great deal of new material has been incorporated. All Sections have been considerably amplified, so that the book is more than twice the size of its predecessor. The improved layout and the provision of an important new feature in the form of a detailed index will, we feel confident, enable readers to find their way more easily about the pages, while the inclusion of telephone numbers for all the principal organisations interested in the sphere of the book should render the volume an ideal desk companion.

The "Who's Who" section has been extended and, although we do not claim that it is entirely comprehensive, we are nevertheless satisfied that it shows a fully representative cross-section of those associated with work in this particular field.

We are very grateful indeed for the valuable help of our Advisory Editor, Lord Horder, and our special thanks are also due to Mr. Richard M. Titmuss. We also wish to thank Mr. T. Fife Clark of the Ministry of Health, Sir Allen Daley of the London County Council, Dr. Lapteva of the Russian Red Cross organisation in London, as well as the Public Relations officials of the many British and foreign government departments who have all co-operated with us so willingly, and also the many and various organisations and individuals to whom we are so much indebted for generous assistance and advice.

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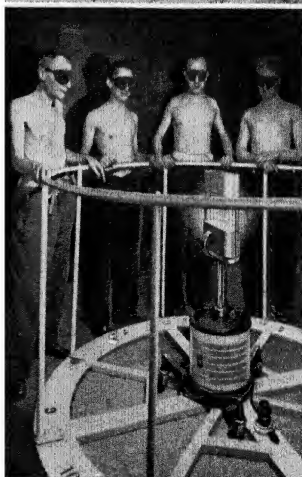
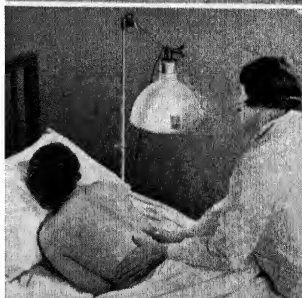


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# INTRODUCTION

BY THE ADVISORY EDITOR

THE interest shown in matters of health and social welfare in this country, referred to in the introduction to the 1944-45 issue of this reference book, by no means diminishes with the passage of time. On the contrary, the problems attendant upon the projected National Health Service, the progress of Social Medicine, the development of Industrial Medicine and the various schemes of Rehabilitation, all conduce to enlarge the scope of the present work. The series of special articles, therefore, takes a wider range and I am hopeful that the choice of subjects, as well as the distinction of the writers, will find appreciation.

Once more I associate myself with the publishers in their expression of thanks to all those who have contributed to the book and in their invitation to readers to suggest helpful features for future issues.

HORDER.



The Rt. Hon. Aneurin Bevan,  
P.C., M.P.  
*Minister of Health.*

# Nutrition and National Health

SIR JOHN BOYD ORR, D.S.O., M.C., M.A., M.D., LL.D., F.R.S.,  
J.P., M.P.

*Director, Rowett Research Institute.*

UNTIL recently, apart from preventing the spread of some infectious diseases, medicine was concerned almost exclusively with the cure of disease. Now more and more attention is being devoted to the prevention of disease and the promotion of health. The two main aggressors of health are inadequate food and inadequate shelter. The worse food and housing are, the greater is the incidence of disease and the higher is the death rate. Thus, for example, in Welwyn Garden City, where there are no slums, the death rate is less than half what it is in the slum areas of some of our cities. In well-fed, well-housed families, the infant mortality rate is only about 30 per 1,000; it is as high as 100 in the families who suffer most from malnutrition and bad housing. It can be estimated that, if all the families in Great Britain had enjoyed food and housing on a health standard, since say 1920, the infant mortality rate for the whole country would have been down to 30, and more than 500,000 infants we buried would to-day be alive between the age of one and 25. Such is the toll which these preventable causes of disease take.

It is difficult to estimate the relative importance of bad housing and malnutrition because they usually occur in the same families; those who are badly housed are nearly always badly fed. But the advance in medical science in the last 30 years has shown that malnutrition is a most important, probably the most important, factor in causing disease in this country. About the time of the last war, it was discovered that a number of commonly occurring diseases, such as rickets and scurvy, the cause of which had long been a mystery, were due to deficiencies of vitamins, minerals and protein in the food. This discovery was immediately applied to the cure of these diseases and then to their prevention, by the supply of cod liver oil, milk and other vitamin- and mineral-rich substances (free or at reduced cost) to the mothers and children of poor families. These public health measures were highly successful. Thirty years ago, about 50 per cent. of the children in the poor quarters of our industrial areas suffered from a gross form of rickets, scurvy or other nutritional disease. To-day, the gross forms of these diseases have almost completely disappeared.

If these gross forms of nutritional disease have disappeared, what role can nutrition now play in public health? These cases of malnutrition, which were classed as "disease," are the result of extreme deficiencies in the diet, and there are all grades of well-being between perfect health and a disease so bad, that people die of it. From dietary surveys made, it appears that about 1930, nearly 50 per cent. of the families in this country had diets which were not up to the health standard. With the rise in the standard of living,

by 1938 only about 30 per cent. were below the health standard. Similar conditions were found in other countries, such as the United States and Canada, and in most other countries the national diet was even worse.

What proof have we that minor degrees of deficiency in the diet affect health? In 1927, it was shown that the addition of extra milk to children in schools in the seven largest towns in Scotland, was followed by an obvious improvement in the health of the children, and in addition, the rate of growth was increased by about 20 per cent. With the extra milk, these school children of the working class began to grow at the same rate as the children of well-to-do families. These children were regarded as being normal healthy children whereas the test showed that they were, in fact, suffering from a considerable degree of malnutrition. Similar experiments have since been carried out in many different countries with similar results. It is interesting to note, however, that in experiments carried out in England just before the war, the result obtained was not nearly so marked, the reason being that between 1927 and 1938 there has been a marked improvement in the national diet.

Now take the case of mothers. In Toronto four years ago, a test was done with pregnant women of the working class. The diet of one group was supplemented by the addition of milk, eggs, fruit, wheat germ and some vitamin D. According to the ratings of the obstetricians who did not know to which group the women belonged, 24 per cent. of the mothers in the poor diet group had a bad record in pregnancy compared with only 3 per cent. in the group with the supplemented diet. The women in the poor diet group took 20 hours in labour compared with 15 on the good diet. During convalescence, 11.5 per cent. in the poor diet group had a bad record compared with 3.5 per cent. in the good diet group. The babies of the poorly fed mothers had a higher proportion of illness during the first six months of life during which observations were made, than the babies of the well-fed mothers. Thirty per cent. suffered from pulmonary and bronchial troubles, *e.g.*, colds and pneumonias, compared with 11 per cent. among the babies of the well-fed mothers. Three infants out of the 100 born in the poor group died but there were no deaths in the well-fed group.

This is one of the many tests which have been done to ascertain the extent to which health and physique could be improved by bringing the diet up to the health standard.

Striking evidence of the effect of food on health is afforded by what has happened during the war. Our war food policy is based on the nutritional needs of the people. Rationing ensures that everyone gets his full share of the food available and the increase of purchasing power of the working class enables practically every family to purchase their full share. Then special provision is made for the higher nutritional needs of mothers and children who have priority for milk, eggs, oranges and who have available a free supply of vitamin concentrates. As a result of this policy, the diet of the poorest third of the population is now actually better than it was before the war. In a dietary survey done in the working class families in Scotland, it was found that there was an increase in the consumption of "protective" foods, especially in the case of milk where the consumption was up by over 40 per cent. The average intake of proteins, the main minerals and all the vitamins—with the possible exception of vitamin C—was well above the pre-war average. Thus, for example, the intake of calcium was up by over 20

per cent. and, largely due to the national loaf, the intake of vitamin B was up by about 40 per cent. This improvement in the diet is already reflected in the improved health of our children. According to one observation made in England, the length and weight of infants at birth are greater than the pre-war average. In spite of the worse condition of housing, the infant mortality rate has fallen below the pre-war level. A well-fed mother gives birth to a healthier infant and a well-fed infant has a better chance of survival. School children are growing faster. Thus, for example, in Glasgow boys of 13 are nearly  $\frac{3}{4}$  inch taller and nearly 3 lb. heavier than the pre-war average and, whereas before the war only about 18 per cent. of children of five years of age had teeth without obvious defects, to-day about 45 per cent. of children coming to school have decent teeth. If this improvement in the health of our children can be made during a period of great scarcity of some of the foods of greatest importance for health, what can we not do after the war when with the same food policy based on the nutritional needs of the people, there can be, within a few years, an abundance of all the foodstuffs needed to bring the diet of every family up to the health standard. Even under existing conditions, these results could be improved because there are still many mothers who do not take advantage of the available milk and vitamin supplements which our excellent war food policy has made available for every family.

For our public health post-war nutrition policy we have a definite standard at which to aim. The requirements of all constituents of food for health are known and the dietary standards have been approved by governments. The following are examples of diets which supply sufficient of every food constituent to maintain perfect health.

**Examples of Diets on Health Standard for Pregnant or Nursing Women and for Child aged 2-3 Years. By League of Nations Committee.**

Pregnant or Nursing Women.							Amount
Protective Foods							per week
Milk	..	..	..	..	..	..	12 $\frac{1}{2}$ pints
Meat (fish or poultry)	..	..	..	..	..	..	1 $\frac{3}{4}$ lb.
Eggs (number)	..	..	..	..	..	..	7
Cheese	..	..	..	..	..	..	$\frac{1}{2}$ lb.
Green and leafy vegetables	..	..	..	..	..	..	1 $\frac{1}{2}$ lb.
Potatoes	..	..	..	..	..	..	3 $\frac{3}{4}$ lb.
Legumes, <i>i.e.</i> , peas or beans	..	..	..	..	..	..	2 $\frac{1}{2}$ oz.
Raw fruit or vegetables to yield	250-500 units of						
vitamin C, <i>i.e.</i>	..	..	..	..	..	..	1-2 oranges
Cod liver oil	..	..	..	..	..	..	1 oz.
<b>Energy-yielding Foods</b>							
Cereals, including bread	..	..	..	..	..	..	3 $\frac{3}{4}$ lb.
Fats, <i>e.g.</i> , butter	..	..	..	..	..	..	{ amounts as needed to make up total energy requirements*
Sugar	..	..	..	..	..	..	
Price total	..	..	..	..	..	..	9s. (at 1938 prices)

\* For purpose of costing, the rations of fats and sugar taken as  $\frac{1}{4}$  lb. each.



**Child aged 2-3 years**

<b>Protective Foods</b>	Amount per week
Milk .. .. .	12½ pints
7 Eggs (or equivalent, as meat or fish or liver, if available) .. .. .	½ lb.
Green and leafy vegetables .. .. .	¾ lb.
Potatoes (and other root vegetables) .. .. .	¾ lb.
Fruit or vegetables .. .. .	not stated†
Cod liver oil .. .. .	¾ oz.

**Energy-yielding Foods**

Fats (butter if possible) .. .. .	2½ oz.
Cereals (calculated as bread) .. .. .	¾ lb.
Price total .. .. .	4s. 6d.
	(at 1938 prices)

**Examples of Diets on Health Standard for Two Adults and Three Children ages 7 to 18 Years. By Canadian Medical Association (1940).**

	Amount per week
Milk .. .. .	38 pints
Cheese .. .. .	1½ lb.
Butter .. .. .	3½ "
Potatoes .. .. .	19 "
Fresh vegetables .. .. .	24 "
Dried " .. .. .	1½ "
Fresh fruit .. .. .	8 "
Dried " .. .. .	2 "
Meat or fish .. .. .	8 "
Eggs .. .. .	1½ doz.
Bread .. .. .	22½ lb.
Flours and cereals .. .. .	7 "

Daily cost, 1s. 3½d. a person.

Cost for family per week, £2 5s. 10d.

† For purpose of costing, one-third of the requirements of the pregnant woman is taken.

It should be noted that these are merely examples. Hundreds of different diets equally good could be made up with these foods in different proportions or even with foods not mentioned. But all diets on a health standard have this in common—they all contain a high proportion of animal products, especially milk, fruits and vegetables.

There has been much dispute about whether malnutrition is due to poverty or ignorance. There is no doubt that both play their part. Before the war, diets like the above were too costly for poor families and the housing conditions of some were such that it was difficult for them to cook proper meals. The case for the poor could not be stated better than was done by Professor Mottram in a previous edition of this book: "It is clear that the optimal diet we have outlined above is not attainable by the poor. Apart from their inability to purchase the food, the domestic appliances, from ranges and stoves to pots and pans to cook the food, are wanting. The lack of facilities in the poor-class home is incredible to anyone of the well-to-do middle classes who has not experienced it." Bad feeding and bad housing go together. The most urgent public health problem is the bringing of these two primary necessities of life up to the health standard. Fortunately we have every reason to believe that this will be done as quickly as possible after the war. The Prime Minister has stated the main objective of post-war planning is a house, food and a job for everybody.

The public health importance of nutrition has been recognised in all countries. On the recommendations of the League of Nations, twenty different countries set up Nutrition Committees in 1937 and delegates from these Committees met at an International Conference in 1938. In 1943 this great world-wide movement was set going again by President Roosevelt, who invited delegates from all the United Nations to meet in America to consider a world-wide post-war food policy. This conference consisted of delegates from forty-four nations, representing 80 per cent. of the world's population. After examining all the available information, they came to the conclusion that, even in the best-fed countries, between 20 and 30 per cent. of the population did not enjoy a diet on the health standard and, in many countries, the majority of the population were in this deplorable condition; that the lack of adequate food was the cause of disease, disability and premature death; and that the main cause of lack of food was poverty. They recommended that every nation should undertake to make a diet adequate for health available for all its citizens, and that all the nations should co-operate to bring freedom from want of food to all men in all lands at the earliest possible date. The British delegation, led by Mr. Richard Law, Minister of State, made a notable contribution to these findings and recommendations, and Mr. Anthony Eden, the Foreign Secretary, accepted the recommendations in the name of the Government, in so far as they applied to the United Kingdom. We can, therefore, look forward to a continuation of the war food policy based on the nutritional needs of the people, but with a relaxation of rationing and other restrictions as food becomes more plentiful. When the recommendations are carried out in their entirety, hunger and malnutrition will be banished from the world with resulting improvement in health and an increase in happiness of the rising generation.

But it will take some years before food is available in sufficient amounts, and every family has a house in which food can be properly cooked. Until then, we must continue, with wartime measures, such as the special provision for mothers and children, the milk-in-school scheme and school meals, and take every means to ensure that families take full advantage of the provision which has been made for them by the Ministries of Food, Health and Education.

But with our eyes on the post-war world, there are other social advantages that can be seen already. Until this war, the technique of blood transfusion was a specialist matter quite outside the human and mechanical resources of a general practitioner or a small cottage hospital. To-day an increasing number of people, even in small villages, are being taught what is now recognised as a vital part of day-to-day medical practice. Blood transfusion has been shown to be invaluable as a means of reducing the risks of maternity. Not only does it safeguard the mother in difficult childbirth, but it affords the only cure for hitherto fatal conditions of early infancy.

Blood transfusion is helping in the treatment of several serious diseases, both in those of a medical and those of a surgical nature. Thus it adds useful months and sometimes years to otherwise doomed men and women. It is of increasing value as a weapon against various anæmias, and it may well prove the answer to some of the chronic types of ill health, which have been so neglected in spite of the fact that these add up to a very considerable sum of human misery. We should add that the social significance of the blood transfusion service wherein each gives for the good of his neighbour, may do a great deal to foster a sense of responsibility for other people's health in the post-war world.

The third great advance in wartime medicine is the perfection of treatment with sulphonamide drugs. It is not many years since Queen Charlotte's Hospital in London showed what could be done for puerperal fever, while Dr. Whitby's mice at the Middlesex Hospital were preparing the way for the human use of "M. and B." as the general public will always call sulphapyridine.

The war has shown that the sulphonamide drugs can be used against a very wide number of diseases of which pneumonia is perhaps still the most important from the peacetime point of view. In wartime their use as a local antiseptic in wounds has given us a weapon against blood poisoning, but more important for the future is the advance in their use against venereal diseases, particularly gonorrhoea. One of the worst problems of the last war was the constant existence of tens of thousands of soldiers suffering from this complaint, cluttering up the hospitals and creating a permanent menace to local morale. Sulphonamide treatment does away with the need for hospitalisation, and allows men to go on fighting and working without loss of time and morale in a useless hanging about.

American statistics show that the incidence of gonorrhoea has gone down from 171 per 1,000 per annum, to eight, thanks to prophylactic use of sulphathiazole. This means that gonorrhoea as a social menace can be brought under control directly we so desire it. The wartime publicising of venereal disease by poster and pamphlet ought to educate the public to the desirability of treating venereal in the same way as any other disease.

Fourth on my list I place the discovery of penicillin. This purely British achievement has given the world the best antiseptic yet discovered. The story of Sir Alexander Fleming's discovery of the penicillin-producing mould is known to everyone, as is the careful research whereby Sir Howard Florey proved the value in human disease of the new antiseptic.

It will be worth while, however, to say a few words upon the later history of penicillin. When the first few cases were experimentally treated with penicillin in 1940, the supply was so minute that the treatment could not be continued to its end, and yet four years later it could be said that there was

enough of the antiseptic for all service casualties who could not be treated by any alternate method. This amazing result involved unceasing research into new methods of production.<sup>1</sup>

At first, small glass flasks were used, but it was soon found that these must always produce inadequate results. We had to look to America to help us at this stage, because it was essential that the mass-production of penicillium should be carried out in a bomb-safe area, and so the first production by the tank method took place across the Atlantic. It was, however, never our intention to be dependent upon foreign supplies and, directly the bombing menace subsided, very large factories for the culture of penicillium in tanks were constructed in various parts of Great Britain. The problem has been a puzzling one for the government, because these factories, which must cost millions of pounds, may at any moment be rendered obsolete by the discovery of how to make penicillin synthetically.

Unceasing research on this problem is known to have reached a stage when a solution enabling us to make penicillin by the ton may be reached any day. On the other hand, it may not be reached for ten years. In any case, however, we know that when the war is over penicillin will be at the disposal of every medical man for every suitable patient.

In war, penicillin is chiefly being used: To prevent infection in wounds so that potentially septic wounds can be treated in the same way as aseptic ones: in the promotion of healing in burns: in dealing with certain chronic and acute infections due to streptococci and staphylococci; and in the rapid curing of gonorrhoea and pneumonia.

There has not been time yet, nor opportunity, to explore all the possible peacetime uses, and we must guard against a tendency in the public mind or elsewhere to regard penicillin as a panacea, as has unfortunately happened with the sulphonamide drugs, and particularly as a camouflage for bad surgery or worse diagnosis.

The fifth wartime advance in the science of healing is mass-radiography. In spite of great achievements, tuberculosis remains one of the greatest scourges of the peacetime world. Our social conscience should be far more deeply shocked than it is, by such facts as that it is this disease which is the largest cause of death in certain age groups of young women.

The discovery of early cases and their isolation, are the best means available for reducing the incidence of tuberculosis; best from the point of view of the individual patient and from the point of view of all those still uninfected whose lives are in danger from every undiscovered case of the disease.

Mass-radiography by itself can do relatively little. We shall have to act upon the implications of the evidence supplied by it. We shall have to isolate every known patient and provide adequate institutions for them. Particularly we shall have to do this in a way which enables men and women to carry on a productive and satisfying daily life. No article of this sort which mentions tuberculosis can do so without invoking the spirit of Papworth.

Having said this, it is almost impossible to over-estimate the potential importance of mass-radiography. Very large numbers of people can be x-rayed rapidly and inexpensively. Inspection of the small films shows a percentage of suspicious cases, and these are x-rayed on larger scale plates from which a smaller number can be shown to be actively tubercular.

Results so far in many different types of group show a regular incidence

of unsuspected early tuberculosis in about thirteen per 1,000 of the individuals.\* The groups have included many thousands in the services, in factories, in offices, in mental institutions and in schools. Nobody claims that no cases of active tuberculosis remain undiscovered by this method, but the social gain of being able to withdraw from the general population so large a number of infective agents is enormous. Moreover, it can be hoped that early diagnosis will in a very few years be reflected in a reduced death rate. We must emphasise, however, that human societies cannot as yet be proud of their record in the battle against this disease, the very existence of which is in some measure an indication of social injustice and preventable want.

Finally, the war has seen great improvements in the whole science of rehabilitation. The social importance of this is inestimable. There was a time when the cure of, let us say, a fractured leg was considered to have been achieved when the patient no longer ran a risk of dying and when his wound had healed up sufficiently to require no further attention.

To-day, the restoration of usefulness to the limb is accepted as part of the work of cure. Moreover, it is seen that a wounded or sick man must be relieved of the lesions of his mind and spirit which are inevitable after serious illness or accident.

Take the young R.A.F. pilot whose face has been rendered featureless by the appalling scars of "Air Force burn." It is not sufficient to graft on skin and to remodel the features sufficiently to keep him alive. He must in more senses than one be given a chance of facing the world again. He must not be left with the gnawing fear that every man and woman who looks at him will shudder at his deformity.

On the one hand this has meant superb advances in plastic surgery with which the name of Gillies will always be associated, and on the other, careful psychological rehabilitation. It is no longer considered enough to amputate an arm, or even to fit the stump with a clever mechanical contrivance to take the place of flesh and blood. The one-armed man has suffered an injury to his spirit. He is all too apt to regard himself as inevitably handicapped in the struggle for existence.

The ideal of St. Dunstan's was to take away the sense of inferiority from the blind man, and we have seen this admirable ideal spread and influence the treatment of all injuries and diseases.

Nobody pretends that the "have I told you about my operation" attitude of certain groups of the more leisured classes is a healthy one, but it is a splendid thing that men who once would have been ashamed of their wounded bodies, should nowadays more often regard their scars as miracles of rehabilitation.

Anyone who has worked at a general hospital and who has human welfare at heart, must have felt heartbroken at seeing patients leaving a hospital which they no longer needed for an everyday world, for which they were not fitted. If we learn the lessons to-day in the hard school of war, this gap in our social welfare services will be closed. We shall make it the criterion of cure that the patient has once more become not merely a complete physical being, but a complete social being; that we have not only saved a limb but the usefulness of a limb; that we save none from death merely to return them to death in life; that in fact the cure of bodies cannot be dissociated from the cure of souls.

\*See: M.R.C. Special Report, Series No. 251, *Mass Radiography of Civilians*.

# Rehabilitation and Resettlement (RHBN\*).

ANNE CARR, M.A.

IN no field of social betterment is progress so rapid and hopeful as in RHBN and Resettlement of the disabled. The Disabled Persons (Employment) Act passed in March 1944 was the first measure for post-war reconstruction to reach the statute book. But planning for full RHBN facilities requires a re-direction and extension of existing medical, social and employment services rather than the building up of new institutions and organisations. Interest in this work is now very keen throughout the country especially among industrialists, medical men and social workers.

From their inception the primary aim both of our Workmen's Compensation and National Health Insurance systems should have been the most rapid and complete restoration of the injured and sick to the fullest measure of health and efficiency attainable. Unfortunately these early social measures were framed entirely with a view to the partial relief of indigence among injured and sick workers, and ignored the problem of achieving their rapid return to normal life. The British Workmen's Compensation Acts dating from 1897, unlike many foreign systems, make no provision for the medical care of the injured, but deal only with the amount of compensation money to be paid for loss of earning capacity. This raises a conflict of interest between the injured worker and the insurance carrier. From a short term point of view it is to the interest of the worker to get as high a rate as possible, and for the carrier of insurance to pay as little as possible. Until the new proposals of the Government White Paper on Social Insurance Part II of Sept. 1944 are carried into effect, this conflict will continue and serve as a strong deterrent to co-operation on the part of injured workers, in carrying through their full RHBN. It cannot be pointed out too often that RHBN cannot be successful without full co-operation and effort on the part of each patient.

Up to the present time our National Health Insurance has not attempted to supply more than the sketchy medical service of the panel system. Owing to the small capitation fee paid, the number of panel patients accepted by the medical practitioner generally prevents his giving as full attention to his panel patients as he customarily gives to private patients. No provision is made for specialised services or treatments, and a limit is set on the prescription of expensive drugs or appliances. No medical service is supplied for the insured worker's family: the sickness and invalidity benefits are inadequate in amount and carry no allowances for dependants. The more provident of the workers have attempted to fill the gaps of the National Health Insurance

\*Rehabilitation has recently become a popular word and is sometimes applied, e.g., in the title of U.N.R.R.A. (United Nations Relief and Rehabilitation Administration), to a restoration of material conditions, industry, agriculture, etc. In this article it is used in its proper and restricted sense of a restoration to health and activity of individuals disabled by injury or illness. For the sake of brevity the contraction RHBN is employed throughout the article.

system, by voluntary contributions to different schemes for provision for themselves and their families against the expense of illness.

To-day our all-party government stands committed to the principles that the state must be responsible for seeing that there is work for all, houses for all, and universal health and education services. These four fundamental needs in a complex, industrialised society, have passed into the realm of recognised social obligations and, whatever differences of opinion may exist as to the programme for carrying them out, no party repudiating them as responsibilities of the State, can form a government in the future. It is in this framework that the future development and application of RHBN services must be considered.

### **The Development of RHBN**

RHBN has received its greatest impetus from advances made in orthopaedic surgery and from the exigencies of war. Modern methods of treating fractures became well known through the work of the late Sir Robert Jones during and after the war of 1914-18, and similar methods were further developed and demonstrated in the famous Böhler clinic at Vienna. The fracture is reduced under radiographic control and immobilised in plaster while the patient is exercised and thus maintains his circulation and general health. These methods not only hasten the union of the fracture but the subsequent disabilities are much reduced from what they were under the old static methods of using splints and imposing general immobility and consequent invalidity on the patient. It is this dramatic development in surgical practice which caught public attention and led to the adoption of a similar outlook in dealing with widely varying types of illness and injury. In the most modern practice the maintenance of the health and morale of the patient is now recognised as being second only to the treatment of the illness or injury. It is the whole man who must be treated and not only a collection of symptoms. This view is the foundation of social medicine and a step towards positive health.

### **RHBN, An Extension of Medical Responsibility**

RHBN has always been the privilege of those who were fortunate enough to be able to pay for the best medical services and advice from their private resources. The men of the fighting services, being the direct responsibility of the State, are entitled to be treated with the unstinted use of the best skills available until they are as fully restored as possible. But the bulk of our population has not had these advantages. They have been treated only until the disappearance of their more serious symptoms, and then left adrift to convalesce and recover full health as best they could.

From the doctor's point of view RHBN is a great extension of his responsibility. It requires that the patient receives medical direction and advice until he is permanently resettled. The doctor, in general practice or in hospital, can no longer ignore the patient's occupational life and social setting. He needs close co-operation with the social workers and the industrial medical services which it is hoped to develop throughout industry. The industrial doctor should be in the strongest position to interpret into suitable occupation the medical record of the worker, for the practical problem of satisfactory resettlement requires an intelligent linking of therapy with a close

knowledge of industrial conditions and the physical and nervous strains of different types of work. While the industrial doctor's main work should be to conserve the health of the workers as a whole, by vigilance over all conditions that might affect their health at work, he should also be available to advise on all cases of particular difficulty in the allocation of disabled people to different types of work. During the war many general practitioners have worked as part-time industrial doctors and, for the first time, have acquired some knowledge of the effect on their health of the conditions of their patients' occupational lives. Progressive medical policy envisages a great extension of industrial medicine which would bridge the gap between medical advice in the factory and medical advice in the home.

### **Activities of the Ministry of Health**

The urgent war need to use all possible manpower in industry brought the employment of the disabled through the Ministry of Labour more before public notice than the progress of RHBN in treatment which has been fostered by the Ministry of Health. The Ministry of Labour came conspicuously into the field with the Interim Scheme for Training and Placing the Disabled in October, 1941, and followed this with the Tomlinson Report to make recommendations for a permanent scheme. On the recommendation of this report the Disabled Persons (Employment) Act was framed.

Meantime the Ministry of Health equipped full RHBN departments at 26 orthopaedic centres and 74 fracture clinics, and in 1943 it extended these services to 450 other hospitals. To-day the Ministry advocates modern RHBN treatment throughout illness and injury in all hospitals. On the outbreak of war the Emergency Medical Service organised by the Ministry of Health took charge of the staffing of over 1,000 hospitals, and this led to a fortunate dispersal of the highest medical skill which used to be available only in London and the larger cities. As far as possible both with civilians and service personnel, different types of cases are sent to the hospitals best equipped to deal with them. Some of the larger hospitals are used for experiment and research and here short courses of instruction are given to representatives from hospitals all over the country. In this way during the past year the number of hospitals having special RHBN departments has doubled, and the use of physio-therapy and diversionary activities for bed-fast cases has become very general.

### **Post Hospital Centres for RHBN**

The majority of patients leave hospital fit to return to work, especially where they have been given modern therapeutic treatments in hospitals equipped and staffed for the work. But even in peacetime, and much more so in war conditions, a considerable number of patients need a period of active, medically directed convalescence away from the hospital or sick room atmosphere, before they return to work. A number of the special RHBN centres were established and were working successfully before the war. One of the earliest was at Crewe for L.M.S. railway workers, while a later and larger one was established for miners by the Midland Colliery Mutual Liability Co. at Berry Hill Hall, Mansfield. The latter has now been taken over by the Welfare Department of the Ministry of Fuel and Power, which has also opened similar centres in Scotland and South Wales.



During the war the fighting services have opened a number of such centres for the post-hospital treatment of their wounded or men who have suffered long illness. The best known of these perhaps are those belonging to the R.A.F. at Hoylake and near Loughborough, where no expense or trouble is spared to restore the patients. Of 1,000 cases of fractured spines in the R.A.F., 856 have been returned to full duty. These centres are large country houses equipped for open-air and indoor games, and with facilities for gymnastics and swimming. They are staffed with physio-therapists, physical training instructors, masseurs and a medical officer for every fifty patients.

In the future we may hope that every group of hospitals will have its own post-hospital RHBN centre to which suitable cases are sent. While the foundations of this work were laid to provide treatment for workers in special industries or services, there is no reason for continuing this feature now the experimental stage is passed. The only question that should arise is whether each particular case would benefit by such treatment.

In addition to these special RHBN centres, a few industrial RHBN centres for people who have suffered long and serious illness and who need "re-conditioning" or hardening before taking up new employment, are needed. It is always well to prevent patients becoming guests of an institution for too long a period—the object of treatment is to move the patient onwards, not for him to become a permanent resident. A special experimental centre for "re-conditioning" has been opened at Egham by the Ministry of Labour and is now working successfully. Here the plan is to help the patients to test themselves with different occupations, a pre-vocational test, and to help them to become accustomed to longer hours of work before entering for new training or returning to their old employment.

### **Psychological Aspects of RHBN.**

It is universally true that a patient's recovery is determined in large part by his state of mind. The patient who is harassed by financial need in his home, or by the fear that he will not again be able to earn his living, is not going to make a good or rapid recovery. In every case the patient needs reassurance on these points, and this should be the first service rendered by the social worker for the invalid.

RHBN is not a process which can be done for people, as it is absolutely dependent on their active co-operation. Every bodily ill has its reflection in the patient's mind, and it is most important that the team of workers surrounding the patient should help to build up his self-confidence, hope and will to recover. The best type of patient is he whose natural resilience leads him to seize every aid to his own recovery and resettlement. For such patients the social worker needs to act more as a reference book than as an aid or crutch. But others, through no fault of their own, need a firmer helping hand especially those who are going to suffer permanent visible impairment. Facial disfigurement most notably leads to every kind of social embarrassment. Here the remedy lies largely in the attitude of the patient's home, and the social worker cannot educate the patient without evoking the assistance and understanding of those nearest to him.

Thus the medico-social worker, who should be in touch with a case from its inception to final resettlement, is a most important member of the RHBN

team, especially on the psychological and social side. In this country she is usually a hospital almoner, though during the war it has been found in the fighting services that a man, gifted with insight and sympathy, can often be of greater help to the severely wounded younger men. The social worker should give close study to the circumstances of the patient's daily life to which he expects to return, and listen to the expression of his fears and hopes and assess his general outlook. In this way she should be equipped to give much useful assistance to the medical and employment advisers.

Up to the present we have been considering patients whose condition is due to a definite physical cause, but those who suffer from disorders of mental or nervous origin are numerous. Both among civilians and the services the number is enormously increased by the horrors, strains and fatigues of war, and many of them can only be dealt with by medical psychologists aided by specially trained psychiatric social workers. Many chronic physical disorders are now recognised to be much aggravated—if not caused—by nervous strains, and once the mind is brought back to balance and nervous control re-established, cure for a chronic state of sub-health is often achieved. Many workers tired by the long war years can be much assisted by skilful treatment in healthy surroundings with suitable, but not too much, diversional occupation. A most promising pioneer effort in this direction is the Medical RHBN Centre opened at Roffey Park, near Horsham, under the chairmanship of Lord Horder. This centre, the first of its kind, is to be used also as a centre for research, experiment and instruction in different types of medical RHBN, and it is hoped that it will be the first of a number of similar centres on the outskirts of our industrial areas. Much prolonged and serious ill-health may be saved by the discriminating use of such medical centres.

### **Training and Resettlement.**

The demands of the war caused the Ministry of Labour to open many training centres in the country, to train new labour before being sent into the munition factories. Under the "Interim Scheme" of October, 1941, these centres are used also for training people suffering from some form of disability, and from these centres they pass into normal employment. To select suitable trainees special employment officers, Disablement Resettlement Officers (now popularly known as D.R.O.'s) are sent to visit the patients in hospital to try to discover what kind of occupation they wish and are fit to take up. After his recovery the patient is sent to train along with able-bodied people in the Training Centres, and the D.R.O. is responsible for finding him suitable employment.

Cases of severe disability needing special training are sent to two residential, voluntary training centres, now subsidised by the Ministry of Labour—St. Loyes, Exeter, and Queen Elizabeth's College, Leatherhead. Here a variety of occupations are catered for and most careful attention is given to the condition and progress of each trainee.

Obviously much of the success of the work of re-settlement must depend on the competence of the D.R.O., who needs a formidable array of qualifications. He must have an intimate knowledge of industrial life and conditions in the district he serves: he must be able to assess the capacities and temperament of the candidate for training: and he needs to interpret the medical

prognosis into possible courses of activity. Usually these officers have time only for a brief visit to the patient and they need all the assistance that the social worker (who has had time to thoroughly study the patient) can give him. During the war it is easy to find some kind of work for all, but in peace it will be more difficult. To attract the best type of officer, he should be not only well trained and widely experienced, but should be well paid too. It is to be hoped that after the war people who have had considerable experience in industry and who enjoy the confidence of employers may be drawn into this most important work.

### **The Disabled Persons (Employment) Act**

This act is framed to set up a permanent organisation for the training and resettlement of the disabled, and it introduces a number of new principles which have never been tried in this country. It creates a register of disabled persons seeking normal employment, and requires that employers of more than twenty workers should employ a quota of such people. The Minister of Labour is to be assisted by a National Advisory Council representative of employers, workers and doctors, and this Council has already been appointed. In addition there are to be district advisory committees to supervise the creation of a register in each district and to advise the Minister generally on the whole problem of the disabled in their respective areas.

The establishment of a register is a proposal which has met with some opposition from those who have had long experience in dealing with the disabled. They find that the greatest desire of disabled persons is that they should be regarded as normal and their registration as a special class may lead to misunderstanding and resentment. It is feared that employers of people who have long worked normally in spite of a physical disability may have pressure brought to bear on them to register in order to meet the necessary quota. Varying estimates are given of the number entitled to register. Some well informed authorities suggest that the number may be as high as two million, or one in seven of all productive workers.

A legal obligation to employ a quota of disabled persons has been imposed in Germany since the last war, and it may well be necessary in Great Britain, especially a few years after the end of the present war. While many employers are public spirited enough to absorb into their works considerable numbers of the disabled (and the former testify that the latter are most reliable workers) yet it is generally desirable to bolster social duty by legal compulsion when public opinion is ripe for such action. Moreover, disabled people generally require work in their home district, and this might be difficult to arrange without a universal obligation to employ them.

A recent American writer has rightly said that the work of the disabled demonstrates "the boundless capacity of human beings to face facts constructively and conquer circumstances." It is this call upon individual courage and effort which forms the strongest appeal to workers in this great social service.

# A National Health Service

HILDE FITZGERALD.

THE Government's White Paper on A National Health Service (Cmd. 6502) proposes nothing less than "to ensure that everybody in the country—irrespective of means, age, sex or occupation—shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available," that the service shall cover "all necessary forms of health care," and that it shall be available to all, free of charge. If its principles and main provisions are accepted by Parliament and embodied in legislation, the British medical services will enter a new phase of their history.

**The Principal Features of the Plan :** It is an imaginative and progressive plan. Medical care will become a public responsibility and every citizen will be entitled to it. It will cease to be dependent upon insurance status, income or other criteria which are irrelevant to health. As in the past, patients will be able to choose their own doctors, and doctors will perform their clinical work free from outside interference. The idea of grouped general practice in health centres will be given "a full trial on a large scale." But neither patients nor doctors will be compelled to participate in the service if they prefer to rely on private practice, and voluntary hospitals will have the option of joining on a contractual basis or remaining outside. The service will be planned as a whole, over large areas, in accordance with the needs of the population, and be paid for out of rates, taxes and a subsidy from the Social Insurance Fund. "To ensure that the service is there, that it is there for all, and that it is a good service," an organisation will be set up which will be "answerable to the public in the democratic way while enjoying the fullest expert and professional guidance."

These are the principal features of a plan which may well affect the life of every man, woman and child in Britain. As it is concerned exclusively with "the direct services of personal health, care, advice and treatment" and not with nutrition, housing and other social factors—which are even more important for health than doctors, medicines and hospitals—it should more appropriately be called a plan for a national medical service. It is emphatic, however, that a new and more positive attitude to health is necessary and that doctors, who want to give the public the full service it needs, must try to become general advisers in all matters concerned with health no less than with disease.

Within the field of medical services, however, the plan is by no means complete. Its gaps in regard to the specialist services and dentistry, have in the meantime been filled by the Goodenough Report on Medical Schools and the Interim Report of the Teviot Committee on Dentistry. As far as the School Medical Service is concerned, there is much to be said for leaving health supervision and inspection of schoolchildren, a responsibility of education authorities, and for postponing the transfer of school medical treatment to the health authorities, until the new service is fully developed. But the exclusion of industrial medicine is an omission which has been widely deplored. Health in the home and health in the factory are two aspects of the same problem, and a National Health Service should be concerned with both.

In spite of these omissions, however, the Government's plan has been widely welcomed. It appears elastic enough not only to absorb all that is good in the present services, but also to expand and comply with future needs. Its solutions to a number of intricate and controversial problems, sometimes by outright changes, sometimes by compromise, have been much discussed since the White Paper was published in February, 1944. The Minister's call for constructive criticism has been answered by the medical profession, the voluntary hospitals, local authorities and public opinion generally. A variety of counter suggestions and amendments—some more and some less constructive—have been poured forth, and a medical negotiating body has been formed to conduct the final negotiations with the Minister of Health before legislation is submitted to Parliament.

**The "100 per cent." Issue :** So far as the White Paper's main object is concerned, there is hardly a dissenting voice. Everybody agrees that the best medical service should be available to all, irrespective of means. The Government wants to put the care of health "on a new footing." Its plan differs from all similar schemes of the past in that it includes the whole and not only particular sections of the population ; that it makes medical need the only criterion for its use ; and that it abolishes all financial barriers between those who provide and those who use the medical services. This seems the obvious and, indeed, the only possible means of achieving the object. The British Medical Association, while approving the object, strongly disapproves of the means. It desires a service not for all who *want* it, as the Government suggests, but for all who *need* it and are unable to pay for it themselves. It therefore favours an income limit on the lines of the present National Health Insurance scheme, which would leave approximately ten per cent. of the population outside the scheme, and preserve a clearly defined field for private practice. Many doctors believe that the medical profession would lose much of its freedom and status, if every member of the community was entitled to a free medical service, and medical practitioners derived practically their whole income from public funds. For this and other reasons, a substantial section of the medical profession would rather see an extension of the National Health Insurance scheme, than a new service based on a new conception.

Those who favour the Government's proposals raise a number of serious objections against such a course. As a transitional measure, until a National Health Service is finally established, it would hardly be worth while to create the large machinery required for an extended health insurance scheme. As a permanent arrangement, however, it would be even more wasteful and unjustifiable to maintain a huge administrative organisation for no other purpose than to ensure that ten per cent. of the population remained outside. Means tests would have to be continued in some form or other, but no practical suggestions have yet been made as to how the well-to-do minority could be administratively defined, without defeating the object of the White Paper, and how a partial scheme for medical benefits could be made compatible with a universal scheme for cash benefits under the social security plan. The argument, that there would not be enough doctors and other health workers to go round if the service was made available to all, might well be answered by saying that the greater the shortage of medical resources, the stronger the case for their proper and economical

distribution in an all-embracing national service. Concerning general medical practice, the panel in its present form would offer no effective means of ensuring a distribution of doctors according to public need, and of developing group practice in health centres. Finally, if the population was divided into two classes, each using a different kind of medical service, the public service—whatever its quality—would soon be regarded as second-best, and as a service for the poorer classes which are unable to afford the superior benefits of private medical care.

**The Administrative Structure :** “ If people are to have a right to look to a public service for all their medical needs, it must be somebody’s duty to see that they do not look in vain.” The White Paper proposes that the administration of the service should be based on the principle of combining democratic responsibility with full professional guidance. It is around the manner in which the Government wishes to apply this principle that most of the criticism of the White Paper has crystallised.

At the head of the new service will be the Minister of Health, responsible to Parliament and advised by a Central Health Services Council, (“ the organised expression of the views of the expert ”), which will have the right to be consulted and to offer its advice on all matters within the province of the expert. It will be appointed by the Minister in consultation with the professional and other organisations concerned, and will include experts of all branches of the medical and allied services. Some of its work will be done through committees with the assistance of additional experts, but the Council as a whole will be responsible for all the views expressed in its name.

The county and county borough councils will form the basis of the local organisation, and combine into Joint Boards “ to plan the whole, although not necessarily to provide the parts ” of the new service over large areas, with the expert help of advisory local health services councils. In collaboration with its professional advisers, the Joint Board will survey the medical needs of the area, draw up a plan for a complete medical service to meet these needs, and submit it to the Minister whose approval will make it binding on all concerned. While planning will thus be in the hands of a single authority—a tremendous step forward compared with the present chaos of local organisation—responsibility for the individual branches of the service will be divided. Each constituent major local authority will be in charge of its own local domiciliary and clinic services, such as maternity and child welfare clinics, health visiting, midwifery, home nursing and the provision of health centres for general practice. But the Joint Board itself will have to provide a full hospital and consultant service in its area by taking over all public hospitals and specialist services and by making contracts with voluntary hospitals.

Although the general practitioner service will be included in the Joint Board’s area plan, it will be administered from the centre, by a Central Medical Board—a small executive body consisting mainly of practising doctors and appointed by the Minister in consultation with the profession. It will work under the general directions of the Minister as “ employer body ” of general medical practitioners, and be concerned with their contracts and fees, the size of their panels, their general welfare and their proper distribution throughout the country.

The declared purpose of the Government’s administrative proposals is,

"to combine public responsibility and a full service, with the essential elements of personal and professional freedom for the patient and the doctor." Nevertheless, they have been severely criticised—by doctors mainly for restricting medical freedom and influence; by voluntary hospitals for not affording them adequate representation; and by local authorities for transferring public hospitals to the new Joint Boards whose efficiency has yet to be proved. Still others say that the "make do and mend" policy in local organisation, has been carried too far at the expense of unified administration.

Many members of the medical profession do not approve of the White Paper's principle "that effective decisions on policy must lie entirely with elected representatives." They are opposed to local authorities playing a prominent part in the service, particularly in view of the need for a general Local Government reform in the near future. In the past, local as well as central authorities have often overruled the expert and disregarded the views of medical bodies whose functions were merely advisory. As a result, the idea of a public medical service administered largely by experts, and not by the elected representatives of the people, has found many supporters in the medical profession. A variety of administrative proposals has been put forward, ranging from syndicalist extremes—a service controlled exclusively by professional bodies—to more moderate ideas of strengthening the expert's influence, by including non-elected professional members in policy-forming bodies. This may be compatible with democratic procedure, if the elected members remain in a substantial majority, and may be held to bring laymen and experts more closely together. It is also suggested that the Central Health Services Council should be elected by the professions, instead of being appointed by the Minister, and that it should have the right to publish its own report. This however, would convert the advisory council of experts into a representative body of "interests," whose relationship with the Minister would be formal rather than intimate. It is likely that the opinions of such a body would carry less weight, than those of a council which was sure of possessing the Minister's full confidence. The voluntary hospitals fear that their point of view may be overruled by other medical interests in the proposed advisory councils, and that the new Joint Boards, as owners of public hospitals, will be biased against them in all that they plan and do. Their solution is the establishment of special hospital councils with planning as well as executive powers, on which both types of hospitals will be equally represented.

Whatever the final shape of the administrative structure will be, the White Paper proposals have undoubtedly clarified the issues to which the present negotiations will have to produce the answers.

**The Hospital Service :** To provide a comprehensive national hospital service in a country with considerable hospital resources, is first of all a problem of co-ordination and planning. The administrative proposals of the White Paper show one way in which it can be solved. Within the general framework, however, there remains a specific question. How can an effective working partnership be brought about between two types of hospitals with different traditions and methods? How can the voluntary hospitals, which are autonomous units, accustomed to be responsible only to themselves, be brought into the public service?

There is full agreement among all concerned that a partnership is necessary. The White Paper proposes that while the existing municipal hospitals automatically become part of the public service (administered by Joint Boards over wide "hospital areas"), voluntary hospitals will be free either to stay outside or to join on a contractual basis as autonomous units. Under their contracts they will undertake to observe the approved area plan, and to perform the services allotted to them. They will also conform to certain national conditions concerning the remuneration of nurses and the appointment of consultants, and submit to inspection by nationally appointed hospital experts. The service will be free to the public, but the payments from public funds to voluntary hospitals will not completely cover their costs.

Some voluntary hospital representatives regard this latter proposal as unfair, but others realise that the hospitals would seriously weaken their case for continued autonomy if they insisted on full payment for their services and left no room for voluntary contributions. Up to the present, the discussions on this and other aspects of the voluntary hospitals' relationship with the public service administration, have been more or less inconclusive. There remains the eternal conflict between a public service for all citizens and charitable appeals of any kind. Whatever device is finally chosen to preserve the traditions and the spirit of voluntary effort under public service conditions, it is certain that the present teaching hospitals will continue to occupy the position of special authority, privilege and independence to which they are entitled as centres of learning and research.

If the Government's proposals in their broad outlines are carried out, a greater similarity between voluntary and public hospitals will no doubt gradually be brought about, and the less efficient units of both types will either disappear, or be raised to a higher standard in order to fulfil their allotted tasks in a planned hospital service.

**General Practice :** The most difficult problems of all arise in what the White Paper calls "the front-line of the service." In general practice not only co-ordination and planning, but also new methods combined with a new outlook will be needed "to ensure that the services which the people get are the services which they need . . . and that they can get them where and when they need them." The isolation of general practitioners, their inadequate equipment and their mal-distribution in the country, are the main difficulties with which the White Paper has to contend.

Under the Government's plan "separate" practice from private surgeries will continue on present lines, but in addition health centres of various types will be provided in selected areas where medical opinion favours the new method of group practice, or where local authorities are ready to experiment. "In the last resort the decision will rest on the requirements of the public interest" and the Minister, who has to approve each area plan, will have the final word in the matter. Much will depend on local enterprise and initiative, and it may well be that in poor and "under-doctored" districts the provision of health centres will be a means of attracting additional practitioners. Doctors who transfer their practices into health centres, will receive compensation for their loss of capital, but it may ultimately be necessary to devise a national compensation scheme in order to abolish the buying and selling of practices altogether. Many critics have said that the White Paper is only concerned with "communal surgeries," and not with



health centres as they are commonly understood—places where all the first-line medical services of an area are brought together. In fact, the Government suggests that there should be experiments in a variety of types, in order to find the best and to adapt the health centre method to the needs of different areas.

A doctor in "separate" practice will receive an annual capitation fee for each patient on his panel, as under the N.H.I. scheme, but as "it seems fundamental that inside a centre the grouped doctors should not be in financial competition for patients," doctors in health centres will be remunerated by salary. This proposal has aroused a storm in medical circles, but it is difficult to see how team work can flourish under conditions of competitive practice, and no workable alternative to salaried employment has yet been offered. However, with bitter experiences of the past in mind, many doctors suspect the Government's intention in regard to the amount as well as the method of remuneration. Adequate medical incomes are a condition of good medical work, and if doctors could be reassured on this point some of their opposition against a salaried service may disappear.

When a public practice changes hands—but not otherwise—the Central Medical Board will have power to declare it redundant, if the area is "over-doctored," and to pay compensation to its owner. In "under-doctored" areas newly qualified practitioners, who want to enter the public service, may be asked to refrain from private practice during their early years. These largely negative measures to adjust the distribution of doctors in the public service, have been strongly criticised as an infringement of the doctors' freedom to practise where he chooses, although in regard to private practice this freedom will not be affected. Methods of attraction have been suggested as an alternative, and they may be useful in extreme cases, but it will hardly be possible or even desirable—to introduce differential payment of doctors on such a scale that it will be sufficient to achieve the object.

Public practice will not debar a doctor from private practice, though the number of his public patients will be reduced in proportion to the amount of his private practice, and "there will be provision to ensure that the interests of patients within the new service do not suffer in any way as a result of this." Obviously, the temptation for the doctor to offer a better service to private, than to public patients, will be great. As many critics of the White Paper have pointed out, a doctor who makes use of this concession to combine the two forms of practice, will place himself in an ambiguous and even humiliating position, because he will be offered fees for a service which the patient can claim free of charge. It is difficult to foresee how the individual doctor will face this conflict and what its effect on the public service will be, but the future demand for private medical attention may become an indication of the success or failure of the public service.

**Conclusion :** The success of the Government's plan will depend on many factors. There are shortages of doctors, dentists, nurses and other health workers, which will cause difficulties for some time to come. Buildings and equipment for health centres and new hospitals will be needed. Finance will play a decisive part, but the total amount of the Government's very tentative health budget appears inadequate. Not only the ultimate shape of the plan itself, but also its execution will be influenced by factors outside the field of medicine. It is impossible to isolate a public service from the ups

# Maternity Services in England and Wales

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## The Maternal Mortality Rate as an Index.

THE first aim of any maternity service is to deliver women with the least possible risk to life and health. And although, as a matter of experience, the new life involved is often safeguarded by the same measures that reduce maternal risk, it is useful to scrutinise the Maternal Mortality Rate for the purpose of comparing one Maternity Service with another. Indeed, a study of this rate is, perhaps, the best defined guide we have to the kind of service which satisfies the primary aim. If space permitted it would, of course, be profitable to study also mortality rates amongst unborn and newly born infants, but it may be said generally that such a study would serve only to reinforce conclusions derived exclusively from the Maternal Death Rate.

Ill health and disability arising out of child-birth are more difficult to assess because they cannot be measured with precision, but there is good ground for believing that morbidity and mortality run hand in hand. According to informed estimates, some twenty women suffer ill health or disability as a consequence of child-birth for every one that dies.

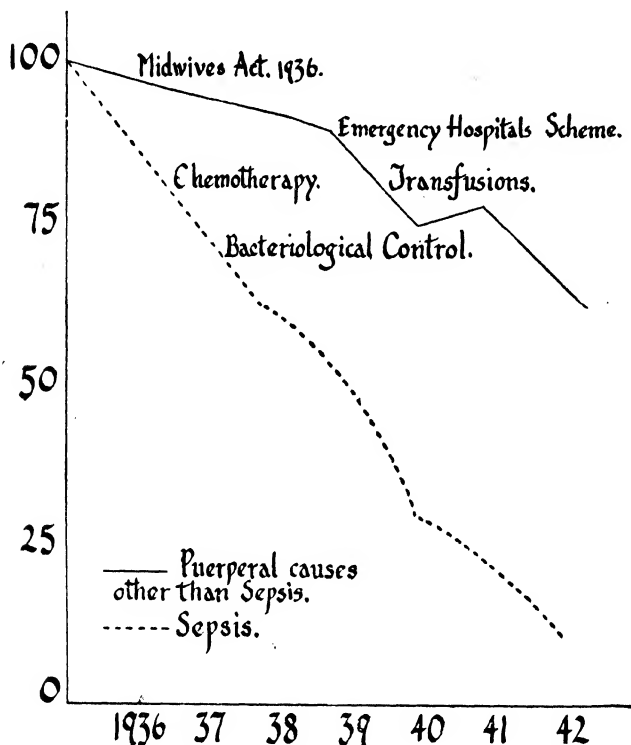
The Maternal Mortality Rate is defined as the number of women who die as a consequence of pregnancy and child-bearing per thousand births and it may be studied in two ways; first by attending to changes in the rate over a period of years, and secondly by surveying the rates for the several social classes and the maternity services they use.

With regard to the first, it is a fact of great significance that although the child bearing woman enjoyed improved economic and social standards in common with other members of the community, whose mortality rates from many causes were favourably affected in consequence, the hazard of pregnancy and child-bearing remained almost unchanged from the beginning of the century until after 1935. During this period it stood at a level of approximately 4 deaths per thousand births. Since 1935, however, the rate has fallen rapidly to only a little over half the pre-1935 level.

It would be wrong to exclude the beneficial effects of material prosperity and improved education, but in the main the explanation of the remarkable improvement since 1935 lies elsewhere. More light is thrown on the causes of this improvement if mortality due to sepsis, and mortality from causes other than sepsis, are considered separately. It is evident from the accompanying graph that the improvement in the septic rate far outstripped the other.

There can be no doubt that improved control of infection based on a bacteriological technique accounted for a part of the reduced incidence of sepsis, but it is since the introduction of new drugs of the sulphonamide group that most of the reduction in mortality has occurred. For, whereas in 1935 a serious case of infection had only a fifty-fifty chance of recovery, by 1940 almost every case treated with the new drugs recovered.

The outstanding factor in the improved mortality from non-septic causes is the application to midwifery practice of recent advances in general medicine. Especially important is the treatment of shocked and bloodless patients by blood, serum and plasma transfusions. Improved standards of midwifery practice since 1936, when the Midwives Act of that year required local supervising authorities to establish a wholetime salaried domiciliary midwifery service in their area, has played a part. The greater proportion of confinements taking place in maternity institutions has also had its influence. These conclusions are reinforced by other evidence which places



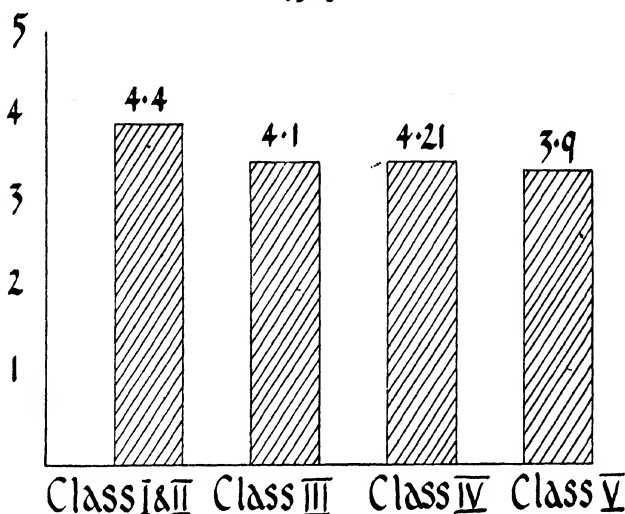
MATERNAL MORTALITY FOR ENGLAND AND WALES  
EXPRESSED AS A PERCENTAGE OF THE 1935 RATE.

them outside the realm of speculation. It is the case, for instance, that maternal mortality has for many years been low amongst booked cases in large maternity institutions, and amongst women delivered in their own homes by Queen's Nurses and Village Nurse Midwives. On the other hand, high maternal death rates have not been associated with poverty and overcrowding, and improved maternity services in individual towns (other

circumstances remaining unchanged) have been associated with a noteworthy diminution in the number of maternal deaths.

It is a singular circumstance that maternal mortality amongst women in the well to do classes, has in many instances been higher than amongst women in the lower income groups ; a state of affairs which contrasts sharply with infantile mortality, which is known to depend on standards of living and education.

PUERPERAL MORTALITY PER 1,000 LIVE BIRTHS OF MARRIED WOMEN  
ACCORDING TO SOCIAL CLASS OF HUSBAND, ENGLAND AND WALES,  
1930-32.

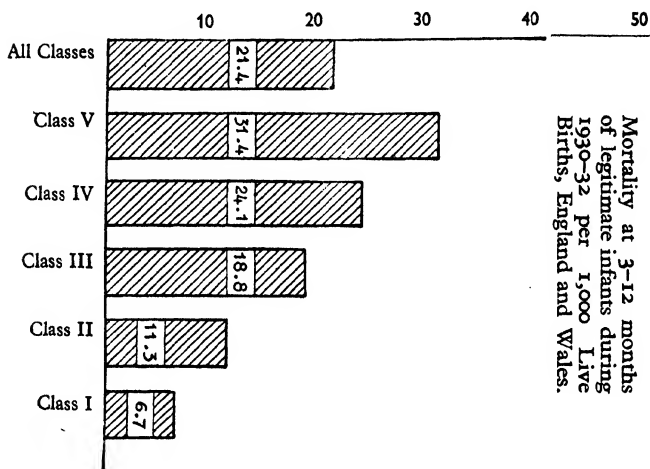


- Class I. Upper professional and managerial strata.  
 Class II. Lesser employers, managers and professions.  
 Class III. Skilled and black-coated workers.  
 Class IV. Semi-skilled, including agricultural workers.  
 Class V. Unskilled labourers.

To disentangle the many factors which might account for the higher rates amongst the well to do is not an easy matter. In this class first births which carry a greater risk to mother and child are commoner, and the later age at child bearing operates adversely. On the other hand, a relatively high risk attaches to seventh and later births, to births following each other in rapid succession and to maternity associated with indifferent health. All these factors tell against the lower income groups. Taking all the evidence together, however, there is little room for doubt that mortality rates are lowest where midwives undertake normal confinements, where the standard of midwifery practice is high, and where recent advances in general medicine have been fully applied to obstetric practice.

The Departmental Committee on Maternal Mortality and Morbidity, 1932, concluded that 45 per cent of deaths were preventable and ventured the opinion that in 19 per cent of cases the primary avoidable factor was an error of judgment, and by contrast in only 4 per cent of cases, lack of facilities. These findings give strong additional support to the conclusions derived from statistical studies.

Without, therefore, minimising the importance of good nutrition and good living conditions, it seems that the great saving of life since 1936 is in the main attributable to technical and administrative advances.



**The Maternity Services as they exist to-day:** Some women are confined in their own homes and others are confined in hospitals or maternity institutions. The steadily increasing demand for institutional confinements during recent years has already been referred to, and to elaborate, in 1927 only some 15 per cent of deliveries took place in institutions, but by 1944 the proportion had risen to approximately 50 per cent. The maternity services fall, therefore, into two fairly well defined groups, institutional and domiciliary. Each group has distinctive features and needs to be considered separately.

**The Institutional Service:** On medical grounds alone confinement in a well equipped institution has many advantages and provides a margin of safety for the patient which can hardly be equalled for every home confinement. Indeed, the outstanding feature of the institutional service is its obstetric self-sufficiency, by which is meant that it can deal with normal and abnormal cases alike, and provide both for the treatment of diseases of pregnancy and for the special care of premature and weakly infants. By contrast the domiciliary service needs the support of an institution for its effective operation. That is to say, institutional provision is always needed

for a proportion of confinements, and for treatment cases irrespective of where confinement takes place.

The greatest advantages attach to an institutional confinement when obstetric abnormalities are present, and, subject to qualifications, the normal case is dealt with equally well in an institution as in the woman's own home. But the institutional confinement is not without its dangers. Neither the greater risk of spread of infections, nor the very real danger of introducing an atmosphere more appropriate to the care of the sick than to healthy women and infants can be left out of account, but both dangers may be minimised—the first, by a high standard of bacteriological control; the second by appropriate administrative arrangements.

The convenience of a close association between a maternity unit and a large general hospital with x-ray, laboratory and consultant facilities need not be laboured, and in the opinion of many the ideal arrangement is to have an autonomous maternity unit associated with a nearby general hospital. A maternity department in a large general hospital is equally suited to its purpose provided that the hospital atmosphere is not allowed to encroach upon normal midwifery.

It is generally reckoned that 20 deliveries a year can be undertaken for each lying-in bed, and that treatment beds should be provided additionally to the extent of about a quarter to a third of the number of lying-in beds. On this basis approximately 65 beds are needed for every 1,000 institutional confinements.

**The Domiciliary Service:** There are still about 2,000 midwives who practise privately, but their number is diminishing. Apart from them about one third of the 7,000 midwives in salaried domiciliary practice are employed directly by the local supervising authorities, and the remaining two-thirds by nursing associations and voluntary hospitals who undertake midwifery on their behalf.

Leaving aside obstetric considerations, it is often less convenient for a woman to be confined at home than was the case a generation ago. The increased mobility of the working population and the splitting up of families, combined with the serious shortage of paid domestic assistance have contributed to the greater demand for institutional confinement for purely social reasons. These changes, it is well known, have been accentuated by the war and they are likely to persist to some extent (though to what extent can only be guessed) in the post-war world.

Social indications apart, it is authoritatively recommended that abnormal cases and sixth and later deliveries should take place in institutions. The Royal College of Obstetricians and Gynaecologists recommends additionally that the institution is the right place for all first confinements which by the nature of things must always be more or less trial labours. Subject to this disposition of cases, the domiciliary service has much to recommend it, provided that it is supported by readily available obstetric specialists and beds for ante-natal treatment. At the expense of repetition it should be emphasised that a domiciliary service is not sufficient in isolation, but must be centred on a maternity institution.

According to an estimate by the Rushcliffe Committee a wholetime midwife working in favourable circumstances is able to attend about 66 cases a year

without a pupil, or 90 cases a year if a pupil is attached to her for training purposes.

For the supervision of domiciliary midwifery local supervising authorities appoint an officer known as the Supervisor of Midwives, who may be either a senior midwife or a specially experienced medical practitioner. Except in the case of large authorities, a non-medical supervisor is usually preferred.

**Ante-natal clinics, Health Education and Social Services :** Before leaving the subject of existing maternity services it is necessary to refer briefly to the functions of the ante-natal clinics and to certain non-medical services essential for the effective operation of a complete maternity service. About two-thirds of all expectant mothers attend at one or other of the 1,800 ante-natal clinics maintained by local authorities or voluntary agencies. To examine in any detail their functions would go beyond the present purpose, but it should be emphasised that unless the clinic medical officer is in a position to arrange for the admission of women to ante-natal beds for treatment, his advice loses a good deal of its usefulness. Like the domiciliary midwifery service the ante-natal clinic therefore needs the support of a maternity institution for its effective operation.

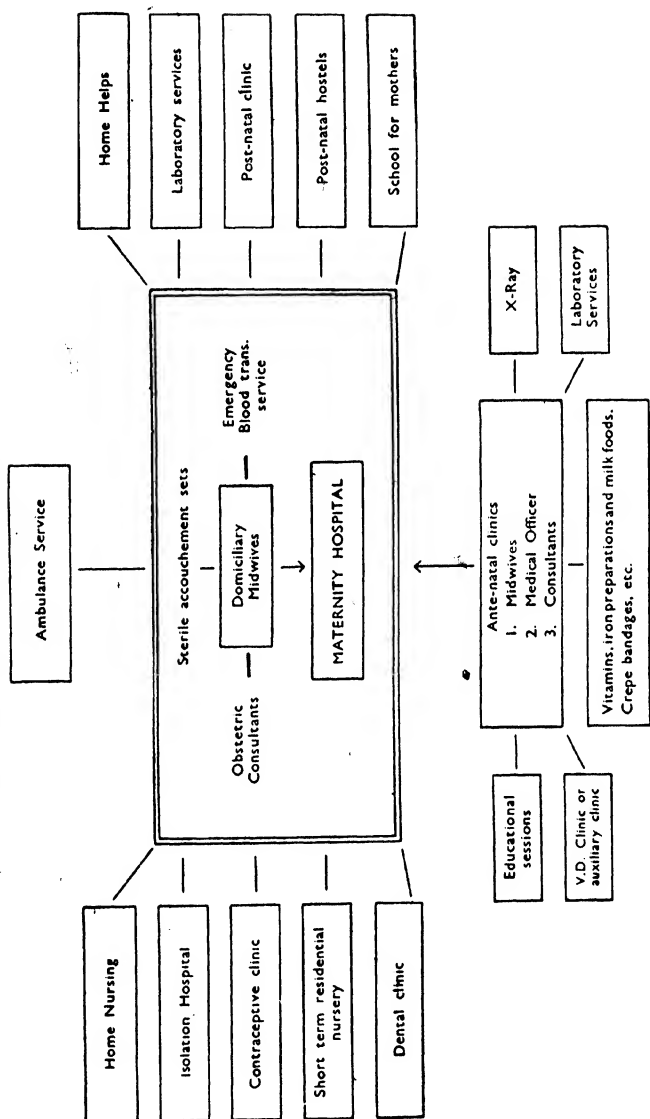
There is still a distressing degree of ignorance about the hygiene of pregnancy and child care. Women still lose their lives because they do not know how to make proper use of existing maternity services ; infants still die because their mothers do not know enough about child care.

To remedy these deficiencies the ante-natal clinic has a valuable and growing part to play in health education. This aspect of clinic work has hitherto fallen short of what is believed to be necessary, not so much because doctors and midwives fail to realise its importance, but because there has not yet been sufficient staff to devote time and individual attention to the women who attend.

Of the many ancillary services (indicated in the accompanying diagram) which go to make up a complete maternity service, there is space to mention only the provision of domestic help for households unable to make their own arrangements. In a strictly medical sense, a Home Help Service or in some instances provision for the care of young children in nurseries or hostels, is an important element in a complete maternity service. For in the absence of such provisions, it frequently happens that the mother of young children is unable to accept institutional treatment or confinement when she needs to do so, and not uncommonly, when she does accept them, she is understandably anxious about her family at a time when her mind should be free from avoidable worry. Without further elaboration it may, therefore, be said that for their full operation both institutional and domiciliary midwifery services need the support of social services of the kind mentioned.

**The Principles Underlying an Effective Maternity Service :** We are now in a position to enumerate the principles according to which a midwifery service of high standard should be planned, and to examine recent government proposals in the light of these principles.

It has emerged fairly clearly that during pregnancy, confinement and the lying-in period, a woman requires the service of a midwife supported by specially experienced medical practitioners to undertake medical and obstetric supervision, and to intervene in cases of abnormality and emergency.

**ELEMENTS OF A MATERNITY SERVICE**



This obstetric personnel on whose individual skill the reduction of maternal mortality and morbidity largely depends, is needed equally for the confinement at home and the confinement in an institution. But we have seen that in order to bring to bear effectively the available obstetric skill, domiciliary midwifery must be centred upon and supported by a well equipped maternity institution. The provision of social services alongside the technical maternity services, the supervision of infant and maternal welfare by health visitors, and education for parenthood, have also been mentioned as indispensable elements of a complete maternity service. It is not difficult to single out the inevitable features of a service which meets all these requirements. Briefly, it amounts to this. Planning must take account, medically speaking, of the primary role of the midwife in normal midwifery and the need to provide her with medical support; administratively, the essential unity of a midwifery service and its social ancillaries.

To turn now to the stated intentions of the Government contained in the White Paper on Health Services (1944), the paper is silent on the subject of midwifery and appears to be in danger of moving away from compendious control where it now exists. It is hardly astonishing that a statement of government policy about the Midwifery Services must await a clarification of broader medical issues and it may be safely presumed that the Minister of Health has in mind all the points made here.

With regard to the proposals touching upon local government functions, it is apparent that to transfer responsibility for institutional beds to joint committees constituted by representatives of county councils and county borough councils, and to make county councils responsible for domiciliary midwifery subject to possible delegations, whilst leaving with many county districts responsibility for ante-natal supervision and social services would, to say the least, greatly reduce the likelihood of providing a closely knit and well integrated maternity service. The case for joint committees with planning functions over larger areas than those of some existing counties and county boroughs is unanswerable, but so far as midwifery is concerned, the advantages of a single authority to take executive responsibility for domiciliary midwifery, maternity beds and social services, emerges from the principles outlined above.

**The Profession of Midwifery and the Rushcliffe Committee report:** The outline would be incomplete without a brief reference to the profession of midwifery, for it is insufficiently understood that, notwithstanding its close connection with the sister profession of nursing, it is, in fact, a distinct profession with its own history and traditions. The close relation which midwifery has to nursing arises out of the fact that midwives have in recent years been recruited almost entirely from the ranks of the nursing profession. This fact accounts in a large measure for the relatively small proportion of women on the midwives roll who practise as midwives, some 15,000 out of about 65,000.

For some years there has been a shortage of practising midwives notwithstanding an ample rate of recruitment to the profession. The high rate of wastage accounts for this, and is due to the choice in favour of nursing exercised by many women who are doubly qualified. It must be admitted that in the past nursing offered many more attractive senior posts than midwifery, a state of affairs which the recommendations of the Rushcliffe

Committee have done a good deal to redress. But one cannot help thinking that the shortage of midwives is attributable in part, to the failure of public opinion to recognise the importance to the community of the skilled midwife, and to give her the place of esteem which is rightly hers.

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# The Problem of Tuberculosis Prevention and Treatment

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TUBERCULOSIS has long afflicted mankind. Its ravages have been seen in mummies of the old dynasties of Egypt. The Greek physicians recorded its clinical features and to Hippocrates we owe the description of the typical consumptive. Our real knowledge of tuberculosis dates from the nineteenth century. Laennec's teaching and use of the stethoscope (1819) laid the foundations of modern knowledge of the disease. Galen (A.D. 130-200) had recognised the infective nature of the disease, but well over a thousand years had to elapse before Villemin in 1865-68 demonstrated this on a scientific basis. The crown was set on Villemin's work by Robert Koch's discovery of the *Bacillus Tuberculosis* in 1882. In the twentieth century, the outstanding features are, the recognition of tuberculosis as a social as well as a medical disease, the value of sanatorium and hospital treatment, and the employment of *x*-rays in the diagnosis and control of treatment, to which fresh attention has been drawn by the development of mass miniature radiography, and the use of artificial pneumothorax and surgical treatment.

**Causation :** Tuberculosis may be conveyed to man by the human or the bovine form of the tubercle bacillus. Infection differs in different communities, and is not always almost universal after an early age. It is high in some cities (*e.g.*, Vienna) and low in country districts. Whether or no the infected individual suffers from tuberculous disease depends, as we shall see, upon a

variety of circumstances. The size of the infecting dose is regarded as of paramount importance by many authorities.

Tuberculosis may affect almost any organ or tissue of the body, but invasion of the lungs is so frequent and so serious that it is convenient to classify the disease into the two forms, *pulmonary* and *non-pulmonary*.

Tuberculous infection may occur (1) by the inhalation of wet or dried particles of expectoration given off from a patient suffering from pulmonary tuberculosis, or (2) by consuming tuberculous milk or other foods tuberculous in character, or contaminated by tubercle bacilli. The main source of infection is probably inhalation of tubercle bacilli in particles of expectoration. The human type of bacillus is responsible for most cases of pulmonary tuberculosis and for a certain proportion of non-pulmonary cases.

The bovine type of bacillus is chiefly responsible for glandular and abdominal tuberculosis and for some tuberculosis of the bones and joints. W. T. Munro was the first to identify a number of cases of pulmonary tuberculosis in adults, in which the infecting organism was bovine. Stanley Griffith estimated that at least five per cent. of human tuberculosis was due to the bovine type, and the Cattle Diseases Committee in 1931 estimated that about 2,000 human deaths in England and Wales were due to bovine tuberculosis conveyed by milk. In addition to this, there is a large amount of suffering, illness, crippling and economic loss for which tuberculous milk is responsible. Professor G. S. Wilson observes: "If all milk for human consumption were pasteurised in licensed plants under adequate supervision, it is no exaggeration to say that tuberculosis of bovine origin would be eliminated."

In spite of years of endeavour and promulgation of the facts by the Ministry of Health, the Medical Research Council, the British Medical Association and other bodies, the people of this land still cannot appreciate the tragic issues involved, or public opinion would have insisted on milk being made universally safe for human consumption.

There are other possible modes of infection, which play a minor part in the dissemination of tuberculosis. For example, human tubercle bacilli through the hands of a consumptive milker, may occasionally contaminate milk and give rise to intestinal tuberculosis; and *lupus* is probably caused by accidental inoculation of the skin with tubercle bacilli.

### **Individual Characteristics and Circumstances**

**Heredity:** It is doubtful whether the offspring of tuberculous parents inherit a special predisposition or susceptibility, but clear evidence of heredity is difficult to obtain in a disease which is infective and prevalent. Equally obscure is the influence of race, for racial habits and environmental and occupational conditions complicate the issue.

**Inter-conjugal Infection:** Married infection is more common than is generally supposed but, according to A. J. Scott Pinchin, in many instances the infection is benign. Pregnancy and prolonged lactation frequently aggravates tuberculosis, if already active, or calls into activity a latent focus of disease. A mother suffering from tuberculosis must be forbidden to nurse her child both for her own sake and for that of the child.

**Family Infection:** A patient with active pulmonary tuberculosis may infect members of his family. Clinical evidence and statistics show that the

incidence and mortality of tuberculosis is much greater among the contacts of open infective cases of pulmonary tuberculosis, than it is in the general population. The medical examination of contacts is a powerful measure of prevention, not only because such examination may detect an early case which might otherwise have escaped recognition and effective treatment, but also because it may reveal the primary infective case in a household, whose segregation may prevent further spread.

**Some Statistics :** At one time tuberculosis occupied first place among the principal epidemic or general diseases as a cause of mortality. It has fallen from that disgraceful pride of place. In the decade 1911-20 the number of deaths each year from all forms of tuberculosis was about 52,000—"a thousand funerals a week." In 1938 this figure was only 26,176 or nearly half the average figure in 1911-20.

As was to be expected, there has been a rise in the figures of tuberculosis mortality during the war years. The rise has, however, been much less on the whole than occurred in the last war, and the figures for 1942 showed a check in the increase. Past experience and the notified figures of persons suffering from tuberculosis suggest that war conditions will be responsible for a temporary increase in the incidence of pulmonary tuberculosis, especially in ex-Service men.

**Urban and Rural Environment :** Mortality from all forms of tuberculosis is higher at practically all ages and in both sexes, in urban than in rural areas. Rural populations are equally susceptible, but among them opportunities for contact infection are less frequent, the general environment is healthier, and the occupational conditions are better than in town dwellers.

**Conditions and Diseases Diminishing Resistance :** Physical over-exertion and fatigue may often determine the onset of pulmonary tuberculosis and an injury is sometimes followed by local tuberculosis.

More important than these are the effects of malnutrition and poverty. When food is cheap and wages are high there are fewer deaths from tuberculosis ; when poverty prevails there is a higher death-rate. War conditions associated with malnutrition or semi-starvation favour tuberculous infection, and many distressing examples of this could be cited from the German-occupied countries of Europe in the present war. The fact that tuberculosis mortality has not greatly increased in this country in wartime, despite many adverse conditions, is largely due to the success of rationing and because a reasonable standard of national nutrition has been maintained.

Malnutrition is usually associated with other conditions favouring tuberculosis, such as bad housing, overcrowding, insufficient ventilation, bad sanitary conditions and defective hygiene. The campaign against the slums and the better housing of the people, indubitably, assist in diminishing potentialities for tuberculous infection. Certain industries which involve the inhalation of special forms of mineral dust—e.g., metal mining, the quarrying and dressing of granite, sandstone, millstone and flint, the refractories industry and sandblasting, are characterised by the incidence of a special form of lung disease known as *silicosis*, among the workers. On this disease active pulmonary tuberculosis may be grafted. The cases are usually of low infectivity. Under the Ministry of Labour, arrangements are in

force for the diagnosis, notification and control of *silicosis*, with compensation to the workers who have acquired the disease.

Asbestos workers contract a similar condition with a liability to pulmonary tuberculosis. In addition, there are a number of other industrial occupations—e.g., printers—in which the incidence of tuberculosis is high.

Certain diseases favour tuberculosis. Of these influenza is the most important. An epidemic of influenza is invariably accompanied by a rise in the mortality from pulmonary tuberculosis. Children who suffer from bronchitis, broncho-pneumonia, measles, whooping cough or scarlet fever, may be thereby predisposed to tuberculosis. In some cases the initial respiratory infection may cause local damage to the air passages and the lungs, and so afford opportunity for the entrance and lodgment of tubercle bacilli, but more frequently these inflammatory conditions appear to bring a latent focus of tuberculosis, usually in the bronchial glands, into activity. Deformities of the chest (whether congenital or brought about by rickets, intrathoracic inflammation or injury) by hampering respiratory movements render the subject of them more prone to tuberculosis. Chronic diseases, provided there is sufficient exposure to infection, predispose to tuberculosis by lowering resistance either of individual organs or throughout the body. Examples of such chronic diseases are: Diabetes, chronic gastric and intestinal affections, anæmia, blood diseases, extreme debility following severe affections (typhus, rheumatic fever, malaria), advanced nervous disease, syphilis and alcoholism.

### **The Prevention of Tuberculosis**

In sketching the problem of tuberculosis, certain preventive measures have been discussed, or are so obvious, that the cause suggests the remedy. The campaign against tuberculosis is an integral part of public health and, inasmuch as tuberculosis is a social disease, every measure for promoting the health and well-being of the community is a contribution towards combating it. The methods of attack must be comprehensive, various and co-ordinated. They can be grouped into general and particular measures.

**General Measures :** The general measures need not be described in detail. They include public health as a whole, with special emphasis on opportunities for physical exercises and recreation ; housing and general sanitation ; good nutrition, including the provision of milk and meals in schools ; a pure and safe milk supply ; medical examination and inspection of school-children ; child-welfare ; hygienic conditions in workshops and factories ; and the avoidance of undue fatigue and of alcoholic excess. They also include measures directed against the conditions and diseases favouring tuberculosis infection.

**Particular Measures :** It is desirable that a complete scheme for the prevention and treatment of tuberculosis should include the following provisions :

#### **1. Staff.**

- (a) The county or county borough medical officer of health as administrator and organiser of the scheme ; (b) the tuberculosis officer ; (c) the health-visiting and nursing staff.

#### **2. The Dispensary.**

### 3. *Institutions for the Treatment of Tuberculosis.*

These should include :

(A) *Institutions for the Treatment of Pulmonary Tuberculosis.*

(1) the sanatorium ; (2) the hospital. When practicable (1) and (2) should be included in (3) the combined institution for treatment, occupational therapy, and employment (hospital, sanatorium, training colony, village settlement) ; (4) the home for advanced cases.

(B) *Institutions for the Treatment of Tuberculosis in Children.*  
Children's Sanatoria.

(C) *Institutions for Special Forms of Tuberculosis.*

(1) for surgical tuberculosis (in connection preferably with a comprehensive orthopaedic scheme) ; (2) hospitals for other special forms of tuberculosis (lupus, scrofuloderma, genito-urinary tuberculosis).

(D) *Arrangements with General Hospitals or Special Clinics for Differential Diagnosis and for the Treatment of Complications.*

(E) *Institutions and Arrangements for Training and After-care.*

(1) technical training sanatoria for adolescents ; (2) industrial centres—residential and non-residential ; (3) the village settlement ; (4) the care committee.

It would be neither the most effective, nor the most economical method for each county and county borough council to make independent provision for each of these needs. Certain of the provisions can be made more satisfactorily and economically by a combination of authorities, or by making special arrangements with institutions already existing outside the area of a particular authority.

### **The Ministry of Health**

The Ministry of Health in its relations towards the tuberculosis work of local authorities is an advisory and supervisory body. It has a special medical department closely concerned with tuberculosis, which is in close association with a number of branches of public medicine and poor-law administration assembled under the Ministry. It is linked up with the tuberculosis work of the Medical Research Council and with the medical services of the Ministry of Education.

The Ministry assists local authorities by acting as a bureau of information upon tuberculosis work and progress, by advising the local authorities upon the development and condition of their work, and by local inspections.

### **Co-operation of the Practitioner and the School Medical Officer :**

General practitioners of medicine play a most important part in the prevention of tuberculosis. No scheme of anti-tuberculosis measures adopted by a local authority can succeed without the full co-operation of the practitioners in the area. As a rule, they first see the patient and refer, not only diagnosed, but any suspected case of tuberculosis to the tuberculosis officer for examination and, if necessary, treatment. The major part of the life of many a consumptive will be spent in his own home and under domiciliary treatment by the practitioner. Consultation between the practitioner and the tuberculosis officer will ensure that the guidance given to patients is not conflicting, and that every advance in specialised treatment shall be available for them.

Early tuberculosis in the child is detected, partly by the tuberculosis officer's examination of child-contacts, but mainly by his examination of schoolchildren referred to him for an opinion by the school medical officer.

**Nurses and Health Visitors :** Nurses and Health Visitors contribute largely to the success of anti-tuberculosis work. Health Visitors are concerned with prevention, with environmental hygiene, and with measures directed towards the removal of infection. Nurses do good service at Tuberculosis Dispensaries, in hospitals and sanatoria and in the nursing of patients in their own homes (District Nursing Service). More tuberculosis nurses are needed. They need not be deterred from this work by the fear that nursing in a tuberculosis hospital or sanatorium involves a greater risk of contracting tuberculosis than nursing in other hospitals. Indeed, experience tends to show that the risk of members of the medical and nursing staff contracting tuberculosis in institutions where proper hygienic conditions are observed is lessened rather than increased.

**Education of the Public :** People need not be frightened about tuberculosis, but the attention of the public should be directed to the steps necessary for its prevention. The National Association for the Prevention of Tuberculosis inaugurated this work, and has done good service in supplementing the information given by the officers of local authorities. The work of the National Council for Health Education in this field is all-important.

Information should be disseminated on general domestic and personal hygiene, and on factors which maintain a high incidence of tuberculosis ; on the facilities available for diagnosis and treatment ; on the dangers of indiscriminate expectoration (this part of the campaign has met with unqualified success) ; and on the evils of overcrowding and of other unhygienic conditions of the home or workshop. The public should realise the vital importance of seeking skilled advice early, and of accepting treatment at once, instead of waiting until the disease has affected working capacity. If the advice of the tuberculosis officer was claimed at the onset of a slight illness, many cases of tuberculosis could be treated with much greater success.

### **Miniature or Indirect Radiography in Diagnosis**

Routine mass radiography is now being employed for the diagnosis of the early case of pulmonary tuberculosis. In skilled and expert hands the results obtained by Dudley and Fitzpatrick, by W. D. W. Brooks and by Trail, testify to the success of this method. Trail found that some 25 per cent. more cases are found in the early stage by mass radiography than by the previous diagnostic methods. The recent detailed report of the Medical Research Council (Special Report Series No. 251) on *Mass Miniature Radiography of Civilians* further shows the value of x-rays as an adjunct to the diagnosis of active pulmonary tuberculosis.

**Treatment :** The facilities provided under a complete tuberculosis scheme for the treatment of all forms of tuberculosis have already been set out. The treatment of non-pulmonary tuberculosis chiefly concerns the surgeon. The work of Gauvain at Alton and of Rollier at Leysin, demonstrated that operative interference in surgical tuberculosis should be the

exception and not the rule; that adequate nutrition, rest and prolonged immobilisation of the patient in a sanatorium environment and in an open-air ward could bring about permanent healing; that natural and artificial light were valuable ancillary measures of treatment; and that the patient (even when immobilised) by the use of special machinery and with technical instruction can be trained in an occupation which may be of service to him on discharge from the institution. This "new learning" stimulated local authorities to make further provision for the treatment of cases of non-pulmonary tuberculosis under their tuberculosis and orthopædic schemes.

Sanatorium treatment for the early case of pulmonary tuberculosis has proved its efficacy over a number of years. It has also been found that many extensive and intermediate cases of pulmonary tuberculosis, and even cases classed as advanced, after efficient hospital treatment, often combined with collapse therapy and surgical measures, may become suitable for sanatorium treatment and attain complete quiescence of their disease. Moreover, treatment of infective patients in hospital has an important preventive aspect, for thereby sources of contact infection are segregated from the community.

Ever since the discovery of the tubercle bacillus, mankind has hoped for the discovery of a serum, vaccine or drug which will kill it. Tuberculin aroused great enthusiasm but is no panacea. Research in the laboratory continues in many directions and it is possible that the wished-for remedy may eventually come through chemotherapy.

In the meantime, once arrest of the disease has been secured the main problem is to enable the patient to earn his own living without breaking down in health. Varrier-Jones solved this problem by establishing at Papworth a village settlement where patients remain under continuous medical supervision and can work under sheltered conditions.

Every patient would not enter a village settlement, if these were generally available. An appreciable number of patients obtain complete restoration to health as the result of ordinary hospital and sanatorium treatment, and are able to resume and continue an active life in their accustomed occupation. Other patients, in which the disease is in too advanced a stage or is too actively progressive, require and prefer either treatment at home or in a hospital in the vicinity of their homes. Lastly, there will always remain a larger or lesser proportion of men and women, who are temperamentally unfitted for, or who are unwilling to enter a village settlement. As the Medical Research Committee on Tuberculosis pointed out, a greater extension of workshops and industries in connection with certain of the larger well-equipped sanatoria is required for this group. The Government now provides special maintenance allowances for patients suffering from pulmonary tuberculosis (Memo 266T of the Ministry of Health), which allows these affected persons to give up work for a while and receive approved treatment. This is a great step forward, but the problem of rehabilitation of the consumptive is not yet completely solved.

**Conclusion :** The State used the years of peace to combat tuberculosis and a comprehensive organisation has been established for the prevention and treatment of the disease. Before the outbreak of the present war, there was an encouraging decline in the prevalence and mortality of tuberculosis. Better methods of diagnosis and treatment of the disease are now available; its social implications are becoming more generally recognised; and it is



being realised that it is of no avail to arrest a patient's disease and then to put him in an environment where he cannot earn a living without breaking down in health. Much has been achieved, but there is still much to be done in the conquest of tuberculosis.

## Rheumatism—A Great Social Plague

The RT. HON. LORD HORDER, G.C.V.O., M.D., B.Sc., F.R.C.P., and  
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RHEUMATIC disease is probably the greatest, certainly one of the greatest, enemies of public well-being in the civilised communities of the world. In England and Wales it is estimated that there are at least a million adult sufferers, and a still larger number, proportionately to their populations, in Scotland and Ireland. In the Overseas Dominions of the British Commonwealth the incidence is also high. In the U.S.A. a recent house-to-house survey of the people of the State of Massachusetts, showed more cases of chronic rheumatism than of heart disease, tuberculosis and cancer combined. To these figures for adult rheumatism must be added those for child (acute) rheumatism. According to the statistics of the London County Council School Medical Service, the figure reaches 2.6 of the total child population, with probably a higher rate in areas less favourably safeguarded by preventive measures. As a killer, rheumatism wears a mask. It does not figure largely in the vital statistics as a cause of death. The majority of its victims are recorded as being from "heart disease"—crippled heart being one of the common after-effects of acute rheumatism. As a torturer and as an inflicter of helplessness, which is as hard to bear as pain, it holds a bad pre-eminence over all other morbid conditions, as evidence from hospitals and from the doctors' consulting rooms bear witness.

Great economic damage is caused by rheumatic disease. In England and Wales it is estimated at £25,000,000 a year. This figure is founded on an investigation of the loss of pay, etc., of a representative sample of workers insured under the Health Insurance Act, and allows for a lesser incidence among other classes of the population. To the direct loss, arising from the worker forced to take sick leave, there can reasonably be added—though it cannot be exactly calculated—a serious diminution of economic efficiency in all classes and all ranks of workers, from the "captain of industry" downwards, since, though keeping at their posts, they have diminished clearness of perception and freedom of movement due to rheumatism. Further, taking into consideration, as one must, the housewife partly crippled by this disease, it is clear that rheumatism takes a toll on the world's production comparable with that of a devastating war; and it is a perennial toll.

**Why so Long Neglected ?** There are several reasons why the rheumatic group of diseases, inflicting as they do, such vast damage to home happiness and industrial efficiency, have been, until recent times, largely neglected in public health effort. One is the fact, already mentioned, that it is a "killer in a mask": its crime is rarely recorded on a death certificate. Another has been the unfortunate misconception that it was an inevitable consequence of life in a cool-temperate climate. True, its incidence is greatest in areas with that climate, but it is also true that in those areas there has been the greatest development of modern industrial civilisation. That development is responsible, undoubtedly, for some of the "promotive causes" of rheumatic disease: the crowding of great populations into cities; the smoke and dust barriers raised against the wholesome virtues of sunlight; working conditions which exact a strain only on a particular set of muscles to the neglect of the rest of the machinery of the body, and which often compel operating in cramped positions and badly ventilated quarters. There are also the difficulties (among city conglomerations) of people maintaining a healthy diet. These and other handicaps on a good habit of life prepare the ground for rheumatism. Climate has little relation to the problem, though calling sometimes for extra precaution in regard to clothing and general regimen. Certainly there is no warrant for the defeatist attitude that we must allow rheumatism's ravages to go unchecked in the more important areas of the globe.

During the past thirty years there has been increasing recognition by the medical profession and laymen interested in health problems, that "war on rheumatism" can be waged with confidence of success, though victory will not come all at once nor without strenuous effort. There is one obstacle—the lack, as yet, of definite knowledge of the prime causative factors in some of the dominant clinical types of the disease. That such factor is an infection in acute rheumatism (rheumatic fever) seems certain; in rheumatoid arthritis, probable; in some other forms of the group of rheumatic diseases, possible. Research so far has failed to incriminate definitely as the causative factor any particular micro-organism. Future attention will no doubt be concentrated upon a more minute and elusive possible criminal—a virus. The recent development of the "electron microscope," multiplying at least fifty times the power of the older microscope, (which utilises light rays and not electron particles) may greatly assist this investigation. The efficacy of the older microscope though enormous, is limited by the speed of light rays, and many virus bodies ("elementary bodies") lie beyond its range.

But it must be stressed that successful treatment of a morbid condition does not necessarily depend on knowledge of its prime cause, though that is always helpful. There are several diseases, the exact bacterial or biochemical origin of which have not yet been traced, but which are nevertheless amenable to skilled treatment.

**Efficacy of Early Treatment:** The medical profession (whilst it must await more complete knowledge resulting from research before it can proclaim full victory over rheumatism) to-day is equipped with a range of treatments which, especially when used in the early stages, can cure, or at least prevent from lapsing into serious disability, the majority of rheumatic sufferers. Emphasis is necessary on the words "in the early stages." Rheumatic disease of long standing is sometimes hopeless of cure. Treat-

ment can promise only alleviation. A Swedish investigator, (Dr. Kahlmeter) from the records of a great number of patients, concluded that cure, or sufficient alleviation to permit of a fairly normal and useful life, is to be expected in 79 per cent. of cases undertaking appropriate treatment within one year of the symptoms developing. After two years the percentage falls to 56 per cent. ; after three years to 50 per cent. As to the results of treatment not classified according to the gap between onset and effective attention, statistical records of various clinics in Great Britain and the U.S.A. as to the proportion "cured or relieved," range from 75 per cent. to 95 per cent. Treating such records with the necessary reserve (called for by the fact that generally there is no long-range check following up the patients for a long term of years) there is yet sound basis for the claim that the majority of sufferers can obtain complete cure, or very substantial relief, from effective treatment. Further it may be confidently stated, that sound medical advice can be markedly efficacious in the matter of prevention, especially in relation to those who, from family history or from some other cause, may be judged as being more than ordinarily susceptible to rheumatic disease, and who should take some special precautions as regards occupations and habits of life.

**Facilities for Treatment :** It is when existing facilities for treatment come to be surveyed that there can be found the reason why still, as in Shakespeare's time, "rheumatic diseases do abound." A pre-war investigation by travelling Fellows of the Empire Rheumatism Council in Western Europe and Northern America disclosed that, whilst there was a fairly even standard of knowledge of how to treat rheumatic disease, and no very great divergence in the degree of application of that knowledge, in no case was there a national system for its *full* application. The British Isles, it must be regretfully admitted, did not occupy a high place in the list of communities taking advantage of the known methods of cure and relief. In this they fell below Sweden and Russia. The National Health Insurance system, providing medical advice and treatment for most workers having incomes beneath a certain rate, did not expressly exclude rheumatic sufferers, but made such limited provision for the special treatments necessary for them that, in effect, all but a very small proportion were excluded. Happily, there is a firm promise now that this position will be put right. Post-war health policy it is announced, will provide for *all* treatment "appropriate to their needs" for those contributing to a Health Insurance Fund, and to their dependents.

The machinery for the administration of the new health policy has not yet been planned in detail ; there are several points still under debate. But, as regards rheumatic disease, a clear path has been indicated by "*Rheumatism—A Plan for National Action.*" Seeking efficiency with economy, this plan should form an acceptable basis for administrative action. It urges an educational programme of self-help to reinforce the work of the doctor and the clinic. It presumes that sufferers—apart from their medical classification into the various categories of the rheumatic group of diseases—can be roughly divided into two classes ; (1) simple cases yielding to standard treatments ; (2) difficult cases needing reference to specialist advice, in some cases to more than one specialist. It proposes therefore, the institution of a small number of specialised treatment centres, (preferably associated with a University Medical School) and, linked with

these centres and under their supervision, the necessary number of local treatment centres, adequately staffed, and equipped with the necessary apparatus for physical therapy. These local centres would be able, with a modicum of aid from the staff of the specialised centres, to deal with the great majority of cases.

For the successful and economical working of such a plan it is recognised that there would be a call for measures of post-graduate education and future student education in the medical profession. There would be need for more physicians with a specialised knowledge of the rheumatic diseases, and, among general practitioners, a more widely diffused knowledge of the symptoms suggesting their existence or the threat of their development.

**Need for Research :** Provision of treatments available in the present state of medical knowledge should, as before stated, secure a dramatic reduction in the ravages of rheumatic disease. But there will be still necessary, a vigorous and sustained programme of clinical and laboratory research, to evaluate suggested new systems of treatment, and to carry on the quest into the exact nature of the infective process which, without doubt, is responsible for some of its forms. World War II has seriously checked this research work over a great part of the world. Wherever the Nazi invasion obtained a foothold the light of science has been quenched. In more fortunate lands there was necessarily some diversion of medical effort from the war on the secular enemies of mankind—the forces of killing disease—to defend civilisation from destruction. With the return of peace research tasks will be resumed on the continent of Europe. Meanwhile the American Rheumatism Association in the U.S.A. and the Empire Rheumatism Council in Great Britain—which work in close alliance—have held the fort and made some notable progress. Recently (1944) the organisation of a Pan-American Rheumatism Association has brought into the campaign the chief South American Republics. There is confident hope that within the next few years world-wide effort in research will bring year by year more knowledge, and therefore more effective control, of this serious social plague.

## Future Developments in the Field of Mental Health

AUBREY LEWIS, M.D., F.R.C.P.

THE need during the war, to make the fullest use of all members of the population and to maintain their health and stability at the highest level possible, has brought about a wide extension of activity in the field of mental health. In a few instances the circumstances have been so peculiar to war-time that the scheme devised to meet them will have to lapse, though not without exerting a considerable influence upon future organisation. This is particularly true of the measures developed for the psychiatric care of children evacuated from large towns.

As the measures had often to be devised hastily to meet urgent situations, they were by no means complete, and in particular they had to be worked with insufficient staffs under unfamiliar conditions. Experimental though they were, however, they have had remarkable success, and have not been in danger of falling into the error—often attributed to psychiatry—of being unpractical and theory-ridden. The attempt to meet urgent problems with inadequate resources disclosed many defects in the mental health services. The defects in question have been for the most part recognised and even harped upon by psychiatrists and others closely acquainted with the existing system in this country and with developments elsewhere (*e.g.* in the United States and some Western European countries) and neither the public nor the responsible authorities had been fully aware of their existence or willing to take the necessary steps for remedying them. That is no longer the case. Experience gained during the war has made it almost certain that the mental health services will in many respects be far more complete than they were before 1939 and that failure in this direction will be recognised as a sin against public health and wellbeing.

It is not in regard to the mental hospitals that the demands for an expansion of mental health services have arisen. There the available space and the staff have both been curtailed. Indeed the increase in the incidence of tuberculosis, to which the report of the Medical Research Council has drawn attention, appears to indicate that the reduction had gone perhaps further than was safe, at a time when rationing and blackout arrangements increased the risks of a spread of tuberculosis in an abnormal population of this sort. Because of the generally high level of mental hospitals in this country, however, the requirements of war did not enforce any further improvements.

In extramural care the matter has been quite different. Special problems that quickly arose in regard to neurosis, disorders of behaviour in children and delinquency necessitated rapid growth in preventive and therapeutic services. Thus by the end of 1943, there were 68 child guidance clinics at work of which 44 had been established since the war. Homes and hostels for difficult children were set up and these remained necessary even after evacuation had ceased to raise the crop of acute problems which were evident in the earlier years. An informative account of the working of 48 of these hostels has been published by the Ministry of Health. It is plain that those running the hostels felt the need of expert help in handling the children's problems of behaviour. There were four hostels to which the most seriously maladjusted children were sent. These were visited weekly by members of a psychiatric team who gave the children appropriate treatment. Eight hostels worked in close touch with an adjacent child guidance clinic at which approximately half the children in these hostels attended for treatment. Sixteen hostels had access to a psychiatrist who advised on the diagnosis and handling of the children referred to him. A psychiatric social worker visited ten of these hostels regularly. Eleven other hostels were likewise visited by a psychiatric social worker—four of them having also the services of a non-medical psychologist. Only eight of the hostels lacked any facilities for specialised advice. The results of this widespread effort cannot be assessed in customary terms of recovery and improvement, since the work was largely preventive in intention, and so far as it was remedial was concerned with disorders of conduct which can only be appraised in relation to the child's environment. There is however general agreement

with the cautious statement of the Ministry of Health that the hostels have attempted to deal with a problem which has never before been met with in this country on a comparable scale—that of providing a suitable environment for many difficult and maladjusted children who are separated from their homes and parents, but for whom a home exists to which they will eventually return. Besides the hostels conducted by local authorities there were others sponsored by voluntary bodies. Thus a residential nursery for difficult children between the ages of two and five was opened in Wiltshire at the request of the Ministry of Health, who also opened the “New World” hostel for difficult boys needing prolonged psychiatric treatment. Miss Anna Freud has directed a residential nursery for children whose lives have been affected by the London air-raids, and there have been similar unofficial arrangements in other parts of the country. The new Education Act makes provision for the recognition and treatment of maladjusted children, as much as for the physically handicapped and ill, or the retarded and mentally defective.

The figures showing how much absence from work was due to nervous disorder in various industries underlined the need for adequate prevention and treatment of neurosis in the civilian population. For this, out-patient psychiatric clinics are necessary. There had been a number of these before the war, most of them staffed, except in London, by doctors working in mental hospitals under the local authority. When the staffs of mental hospitals were depleted in order that the needs of the Services might be met, many of these clinics became less active. Moreover, in some instances the clinics had not been concerned mainly with the treatment of neurotic illness. There has of late, been a steady increase in the out-patient facilities of this sort, in response to an obvious demand, though very much remains to be done. The Ministry of Health in November-1942, initiated a survey of the existing arrangements. The results of this survey, which has been directed by Dr. C. P. Blacker, will be indispensable in planning the psychiatric part of a comprehensive health service for the nation.

The prevention of neurosis is closely linked with the industrial and social conditions under which people live. The Medical Research Council has sponsored an investigation into the incidence of neurotic illness in certain branches of industry. The inquiry has been completed, but the results are not yet available. In London psychiatric out-patient departments dealing with industrial problems have been set up at the Maudsley Hospital and elsewhere, and at Roffey Park a hospital has been developed to provide in-patient care for such conditions.

Another development has been in the field of mental deficiency. Hostels have been organised for men on licence from certified institutions, so that they could do agricultural work for the county War Agricultural Executive Committee, at a regular wage. These hostels are situated in Gloucestershire, Hampshire and Shropshire. The experiment has been successful. The men, though they are certified defectives who could certainly not live independent lives, have been able to do useful work under sheltered conditions, and it is the wish of the Ministry of Agriculture that the hostels should continue after the war. It is equally the wish of psychiatrists and others, who have seen how beneficial to the defectives themselves is this half-way house between institutional life and independent life in the community.

The organisation and conduct of this experiment have been in the hands of the National Council for Mental Health. The Council incorporates three bodies which, before the war, worked independently, viz., the Central Association for Mental Welfare (which cared for defectives), the Child Guidance Council and the National Council for Mental Hygiene. Just before the war the Faversham Committee had recommended that these voluntary bodies should fuse. The last stage in the fusion has now been reached. The Provisional National Council for Mental Health was formed early in 1943 to carry on the work previously done by the three constituent bodies and the Mental Health Emergency Committee. The only other considerable voluntary body dealing with mental health is the Mental After-Care Association, which has continued its work during the war. The educational, social, and other activities of the National Council for Mental Health are widespread and have been supported by Government grants.

Many interesting wartime developments in the field of mental health have arisen out of the needs of the fighting Services. It became evident that neurotic illness developed more frequently among those, whether men or women, who were given jobs unsuitable to their abilities. Selection for appropriate employment became therefore not merely a means of making the best use of restricted man power, but also of lessening the likelihood of neurotic breakdown in susceptible persons. Psychological tests, psychiatric interviews and other technical devices were therefore developed to meet the requirements of each of the Services. An extension of this selection procedure has occurred in the National Fire Service where a Selection Board has been established in London, with a psychologist and psychiatrist on its staff, to examine candidates for promotion.

A special scheme has been instituted for restoring to useful civilian life those who have had to be discharged from the Services on account of psychiatric disability. The proportion which these bear to all persons discharged on medical grounds is high, and the Government took account of this in deciding to set up an after-care scheme, which should ensure that the psychiatrically disabled man, on returning to his home, should have the benefit of all the skilled guidance possible, to make him able to work again and live a healthy life. The machinery set up provides that a psychiatric social worker of the National Council shall in appropriate cases visit the hospital before the man is discharged from the Service. The information then obtained is transmitted to the corresponding psychiatric social worker in the area where the man's home is situated, and it is this worker's business to assist the man in any social or industrial problems about which he is in difficulties. The scheme is additional to the Government's re-settlement measures, with which it is of course closely co-ordinated, and it is related to the working of the Disabled Persons Employment Act.

The social history of ex-Service men whose neurotic illness was the cause of their discharge has been studied in various groups. A thorough survey of a representative national sample has been carried out during the last twelve months, and the results suggest that a comprehensive mental health service is necessary if much maladjustment and a considerable waste of potential ability is to be avoided.

The common and usually the chief limiting factor in the development of various schemes and mental health facilities referred to above has been the shortage of trained staff. Psychiatric social workers are key workers essential

for carrying out these measures but, because of the relative paucity of the demand for them before the war, far too few had been recruited and trained to meet all the calls made upon them in the last five years. The number of these students entering the Mental Health Course at the London School of Economics each year was never more than 25, a number which corresponded roughly to the number of available posts. The increased demand during the war has resulted in a similar course being instituted in Edinburgh recently. It has been sometimes assumed that the deficiency in trained workers has been due to the London School of Economics not being able to accept more than a very small number of students, and that the situation would be remedied by opening a number of training centres at different Universities throughout the country. This view represents a mis-statement of the position. The difficulty has been, not in finding room for students, but finding a sufficient number of students of the requisite qualifications to take the course. There are few professions in which it is more necessary to ensure that only those who have the necessary temperamental qualities (as well as previous social training) be allowed to undertake it. It has therefore been the rule to select very carefully from among the applicants those who are fitted to engage in this delicate work. Setting up more training centres would not in itself ensure a richer flow of suitable candidates, though indirectly it might have this effect. The institution of more training centres is therefore to be welcomed, provided that as much care is taken as hitherto, to select recruits of requisite standard and to provide them with a training which does not err on the side of excessive attention to some one aspect of psychiatry. The number of trained psychiatric social workers now available in Great Britain is 241.

The development of mental health services is so clearly dependent on a sufficient number of trained persons, that much attention has been given to the problem not only as it concerns psychiatric social workers, but also with reference to doctors, nurses and occupational therapists. The Goodenough Committee on Medical Education made a number of proposals to ensure that all doctors should have a better grasp of the psychological aspect of medicine, and to bring about a higher level of psychiatric education among those who specialise in the subject. More detailed proposals to the same end are contained in two Interim Reports of a Committee of the Royal College of Physicians.

The increasing interest taken in the welfare and problems of the older groups of the population has a psychiatric aspect, since the mental changes even of normal old age are such as may be aggravated or diminished by circumstances, and a large number of old persons exhibit manifest mental disorder, sometimes amounting to dementia. The Nuffield Foundation established a Survey Committee on the Problems of Ageing and the Care of Old People, under the Chairmanship of Mr. Seebohm Rowntree and with a Medical sub-committee. It appears likely that the data now being collected will point to desirable modifications in existing ways of caring for the aged, to ameliorate the burden of mental disorder incident to this period of life. Studies both in America and in this country have shown that, whereas half a century ago mental disorder necessitating admission to a mental hospital was a disease of the earlier part of adult life, it is now increasingly a disorder of the elderly.

The various physical methods of treating mental illness which have been



introduced within the last ten years, would probably have exerted more influence on the general plan of mental health services if it had not been for the war, which curtailed the use of any procedures (such as insulin hypoglycemia) that make considerable demands on nursing and medical skill, and diverted to the armed forces, staff and facilities that would otherwise have been devoted, *inter alia*, to investigating and extending methods of physical treatment. The same causes have been responsible for the relative decline in psychotherapeutic activity in out-patient departments and clinics.

Surveyed over their whole extent the mental health services appear to be ripe for extension and overhaul. During the war any doubt as to whether mental health services (except for the insane) are a luxury, has been dispelled. The social aspect of the psychiatrist's work has come more and more into prominence, and it is widely recognised that indispensable preventive work may be done by him, in alliance with the psychiatric social worker and the psychologist. The mental health services instead of being something apart from the rest of medicine are evidently on the point of taking, in civilian life, their essential place within the structure of all preventive and therapeutic medicine.

## Nursing

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NURSING has sometimes been described, perhaps not without reason, as the Cinderella of the professions. Yet it has a long and fascinating history; its traditions of service are second to none, and its future, if recent suggested reforms are put into effect, promises great potentialities. In the words of the Horder report: "Nursing is not merely an item of the nation's medical service, but a profession parallel to that of medicine, occupying an appointed and increasingly important place in the national plan for health." Educationists are also increasingly recognising the fact that (although it is essentially a practical art and requires skilled technique) nursing offers a life of scientific opportunity, and that the training of the nurses of the country, given a liberal outlook and a carefully planned curriculum, could be developed into one of the great national educational movements. It certainly absorbs a great number of men and women. There are some 123,000 state registered nurses alone in the country to-day, not counting student nurses in training, and the newly recognised assistant nurse who has recently been enrolled in thousands by the General Nursing Council.

When the 1944-45 edition of *Health and Social Welfare* was published, it gave an inspiring picture of the prospects of the national health field. Nearly every aspect was described in detail. Many will remember the jingle which tells how the battle was lost "all through the loss of a horseshoe nail." The horseshoe nail in this case is the nursing profession of the nation.

No matter how perfect the paper plans are—how numerous, well trained, or well distributed the consultants, general practitioners and welfare workers,

or how adequate the hospitals, clinics and rehabilitation centres—the battle will be lost unless the health services can be “underpinned” and supported by a numerous and well trained nursing staff. It is useless to set up hospital beds if the nurses are not there to give round-the-clock care ; useless to preach preventive medicine unless there are health visitors to man the clinics and drive the lessons home to the people ; useless even to approve training schools for nurses, unless there are enough qualified sisters, tutors and ward sisters to teach the nurses the underlying reasons and the performance of, the complicated techniques of to-day.

What is the nursing profession itself doing to meet the situation? It is not idle. Its own statutory body, the General Nursing Council (which is registering over 7,000 new nurses every year) and its own powerful professional association, the Royal College of Nursing—with some 37,000 trained members and another 16,000 members in its junior branch, the Student Nurses’ Association—are perhaps two of the hardest worked organisations in the kingdom. The Government White Paper on a National Health Service has sketched the shape of things to come. At the moment of writing, certain vital adjustments in the plan are the subject of negotiation between the nurses’ representatives and the Minister of Health, and the Royal College of Nursing has published a memorandum on the subject. By and large, the nursing profession accepts its main principles and intends to do its utmost to make the plan a success. Like the signatories of the Goodenough Report on Medical Schools, however, nurses insist that “the spirit of education must permeate the whole service.” Government blue prints are not, of themselves, enough.

An adequate supply of well trained nurses—trained in all the manifold branches for which their services are required—is the profession’s objective to-day. After the last war the state registration of nurses, under the control of the General Nursing Council, was regarded as a great step forward. It distinguished those who had been properly trained in the science and art of nursing from the “amateurs,” and as often as not, from the unscrupulous imposter. It brought order in to a situation which, before, had been chaotic.

The present war found the profession ready for the next step. Medical science, and with it nursing, had become increasingly complex ; the demand for skilled nurses had become insatiable. Gone were the days when “a pair of list slippers and a kind heart” were the nurses’ main stock in trade. The time had arrived to make the most of the professional skill available, in short to rationalise the service. To do this a new grade of nurse was created, equally well trained, though in a more limited sphere, and well able to carry out the many simple nursing procedures which can safely be performed under supervision. So, in 1943, the Nurses Act was passed, recognising by Statute the work which the assistant nurse had already carried out for years in institutions for the chronic sick, regularising her services, abolishing anomalies and safeguarding the position of her senior partner, the state registered nurse. This step caused misgiving among the more conservative nurses, but their arguments were well and truly refuted in the first report of the Nursing Reconstruction Committee, set up by the Royal College of Nursing under Lord Horder’s chairmanship. (The recommendations contained in this document were almost all embodied in the subsequent Act).

With regard to the basic training of the nurse, it is generally agreed that

it must be much wider. It must take advantage of the grouping of hospitals under the health plan, and provide experience (but not necessarily qualification) in the fields not hitherto covered by the misleading term "General trained nurse"—experience in tuberculosis, in the nursing of infectious and mental diseases, in the rudiments of obstetric care, and in the nursing of the chronic sick. There must also be some insight into the preventive and social aspects of nursing. Here again the nursing profession must fall back on rationalisation if such a course is to be adequately covered. The student must be a *real* student, and not just a "pair of hands" primarily of use to the hospital which undertakes to train her. She must not spend her time on repetitive tasks which have ceased to have educational value. To relieve her of this work there must be far wider employment of trained nurses and domestic orderlies, and in many hospitals the newly enfranchised assistant nurse must come into her own.

More and more secondary schools are hoping to provide the scientific background necessary for nurses in training. Pre-nursing courses recognised by the Ministry of Education and the General Nursing Council are developing throughout the country. These courses not only continue the prospective nurses' general education, but prepare and enable her to take the theoretical part of the preliminary state examination while she is still at school, thus linking nursing and general education, and lightening the student's burden when at the hospital stage, she is taught to apply her knowledge to actual patients and their maladies. For those who cannot stay at school so long, schemes of "earning and learning" are needed, still linked with general education, and again under the auspices of the education authorities. By this means no good potential nurse is debarred from training for lack of money.

The same principle should be carried out in the sphere of post-certificate training, for to the promising nurse, the widened basic course is only the first rung on the professional ladder. The branches of post-certificate work are numerous and varied—industrial and district nursing, health visiting, tutoring, nursing administration, dietetics, the nursing of tropical diseases, and so on. Training courses, together with a limited number of scholarships, exist in all these specialities but, for the ordinary nurse student seldom well endowed with this world's goods, the cost of fees and maintenance is formidable. Therefore the profession rightly maintains that nursing training, including post-certificate education, is a national responsibility and that its cost should be partly borne by the state.

Space precludes anything but a passing reference to the various types of national machinery, through which the nursing services are adjusted and controlled. Like the teachers, nurses now have their national salary scales. The Division of Nursing at the Ministry of Health, set up in April 1940, will play an increasingly important part when the National Health plan comes to be implemented. Meanwhile, as a wartime measure, problems of recruitment and distribution are negotiated by means of a National Advisory Council of the Ministry of Labour and National Service.

The nurses' own professional organisation, the Royal College of Nursing, is to the nurse what the British Medical Association is to the doctor, while in the international field—and it is worth remembering that nurses were the first body of women to organise internationally—the character of their calling has always ensured ready contact and sympathy with nurses of other

ances, creeds and outlooks. The Royal College has played a considerable part in the organisation of both British and foreign nurses for the relief abroad, and it is envisaged that more and more nurses of the widest intellectual and professional attainment will be needed to take their place beside doctors and social workers, not only in planning and carrying out a National Health Service, but to ensure that nursing will play its full part in helping to re-establish the peoples of our own and other nations in the post-war world.

## The Health Visitor

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THE health visitor is a trained social worker whose qualifications are prescribed by statute, and no person may be appointed as a health visitor for the first time unless qualified in accordance with the regulations.

The standard qualification is the Health Visitors' Certificate, for which two types of training are recognised, and candidates for examination must produce evidence of either :

1. Having undergone a two years course of training in Public Health work ; had six months' training in a General Children's or Fever Hospital ; obtained the Part I certificate of training of the Central Midwives Board ; or
2. Having undergone three years' training in sick nursing in a General or Children's Hospital approved by the General Nursing Council ; obtained Part I certificate of training of the Central Midwives Board ; completed a course of training in Public Health work lasting for at least six months—which period is to be extended to nine months as soon as conditions permit.

Health visitors are appointed mainly by the welfare authorities of local authorities, but they may also be appointed by voluntary bodies to whom certain powers concerning maternity and child welfare have been delegated by welfare authorities.

A national scale of salaries, and of conditions of service, is in force.

Health visitors are employed under the central control of the medical officer of health and may be supervised by a medical officer designated for maternity and child welfare, or by a superintendent health visitor. Contact with health visitors can be obtained by application to the local public health department or maternity and child welfare centre.

The duties of health visitors vary slightly under different authorities. In some districts they are concerned only in the supervision of the health and welfare of expectant and nursing mothers, and of children under five not attending a school recognised by the Ministry of Education, while in others this duty is combined with that of school nursing, mental deficiency, or tuberculosis visiting. Whatever the range of duties may be, the primary function of the health visitor is to visit the homes of a community and therein to teach hygiene and the means of attaining to a healthy way of life. This simple statement of fact is capable of wide interpretation and, in her

daily round, the health visitor is confronted by many problems associated with human relationships and social conduct. The health visitor therefore does not work as an isolated unit but, by friendly co-operation with the several social workers in her district, both official and voluntary, brings to the solution of the many problems the knowledge, wide experience, and often practical assistance, of the team of which she herself is but a part. Her colleagues will normally include the relieving officer, the property manager, the school nurse, the sanitary inspector, the probation officer, the almoner, the factory supervisor or industrial nurse, the Queen's nurse, the district midwife, the local inspector of the National Society for the Prevention of Cruelty to Children, the moral welfare worker, and the secretary of the adoption society.

During the period of hostilities new contacts have been made to assist in solving problems arising in a society organised for total war, not least of which have been those arising from the impact of war on the home and the disruption of family life. Evacuation and billeting officers have been met; food control executives, milk officers, service welfare officers, the women's voluntary services and many others have been contacted—all in bringing to a focal point a diversity of interests with a common object, the preservation of child and family life.

The daily round includes attendance at child welfare centres, ante-natal clinics, and kindred institutions in which advice on mothercraft and child nurture is given, and in home visiting. The proportion of time devoted to these two aspects of the work vary widely. Some health visitors spend one half day per week on clinical duties, while others may spend five half days. Health visitors generally are of the opinion that a higher proportion of their time should be spent in home visiting and that in this, their case load should be regulated.

Satisfactory work can only be accomplished when sufficient time is allowed for regular and repeated home visiting and the linking up with other medical and social agencies—a by no means universal practice.

It is to be remembered that the health visitor performs the only mass observation made of the pre-school children and that, if the service is understaffed, the possibility of the "missed case" and the individual tragedy, looms large. Official investigation after the event does not represent sanity in local administration. There is no official limitation to the case load of health visitors and staffing standards vary widely. It is interesting to note that under the new Education Act, in connection with which regulations have now been published, the maximum size of a class of under threes is 15 pupils. A health visitor has often to supervise over 1,000 infants in addition to clinical and other duties—not from a classroom, but from door to door in all weathers year by year.

In visiting the homes, the health visitor serves four functions. She is a trained observer, a teacher of mothercraft, an adviser on matters relating to the health of mothers and children, and she should endeavour at all times to promote communal health.

The success of her efforts depends on her approach to the mother, on the degree of confidence she may inspire, and on the regular continuity of her contact with the home over a period of years. Trained to observe, she must assess those factors which she considers deterrents to the health and well-being of the household, and must seek to eradicate these by advising

parents on the solution of the several problems which may be apparent. She must strive at all times to inculcate the spirit of selfhelp and resolution, particularly in that minority group so often referred to as "submerged." In her general survey she is concerned with the structural condition of the home and with its environment; with the standards of nutrition and of personal and domestic hygiene attained therein, as well as with the economic standard and social habits of the household.

Within this orbit lies the whole social background of health and of disease. The social evils of bad housing, poverty, mental deficiency, low standards of personal and domestic hygiene, gambling, debt, domestic strife, cruelty and child neglect, are all too familiar to the health visitor; and yet it is in the raising of the standards of the social background that the health visitor hopes to make her contribution towards communal health.

The more individual aspect of her work is in supervising the health of expectant and nursing mothers and of pre-school children. In this she is the officer designed in several Acts of Parliament, and referred to in numerous ministerial instructions issued from time to time in memoranda form by the Minister of Health. Legally her power of entry into a home is limited to certain specific duties in connection with the fostering of children and child adoption, and for her general duties she must depend on the goodwill established by her predecessor, and the friendliness she herself has created.

Under Part V of the Public Health Act, 1936, it is the responsibility of any person in attendance upon a mother at the time of birth, or within six hours thereafter, to notify the fact to the medical officer of health of the area in which the birth took place.

A card index of these notifications is made under all welfare authorities, and the health visitor of each area is supplied with cards relating to infants born and normally resident in her area. The health visitor visits the newly born child as early as practicable after discharge from the hospital, or after the doctor or midwife has ceased attendance at home. She re-visits at regular intervals until the child is admitted to school.

General instructions adapted to the age of the child are given at each visit, on infant feeding, hygiene and general management. This instruction embraces a whole range of subjects, and mothers are encouraged to ask questions and to present their own difficulties. Mothers will also be invited to attend the child welfare centre, where each will receive further instruction in child care and where routine medical observation of her infant will be available. On each visit the health visitor will note the child's progress or retrogression, and will advise that the family doctor be consulted if the condition is such that in her opinion, medical advice should be sought. All diagnosed defects will be noted and the child followed up until the defect is remedied.

The child welfare service also offers a wide range of specialist treatment generally based on the child welfare centre, to which the general practitioners have access if they care to refer their child patients for diagnosis and treatment. Such treatment schemes are staffed by doctors of consultant rank, and among others include an orthopædic surgeon, an ophthalmic surgeon, a dental surgeon, an aural surgeon, a paediatrician, and a psychiatrist.

The health visitor in daily routine visiting who is quick to notice deviations from the normal in individual children, is often the means whereby children

are brought under treatment by these specialists and thereby serious and lasting defects may be prevented.

While maintaining mass observation of all the children in her area, there are special groups which are the priority of the health visitor's interest. These are the prematurely born, the children of unmarried mothers and unfaithful wives, children fostered for payment (the onetime victims of the baby farmer) and children placed for adoption under the Adoption of Children (Regulation) Act of 1939.

Children living in homes of low standard hygiene—the infested—are a difficult group bordering on the ill-cared for and neglected, which are the health visitor's despair. This problem group is so often allied with low standard mentality or actual mental deficiency in the parents, that there appears to be little hope of raising the standards of such children while they remain in the custody of their parents.

The health visitor may report a case for prosecution, and a child may be removed on a magistrate's order, and the parents be subsequently sentenced to a term of imprisonment; but the return of the child to the custody of the parents after the term has been served only completes a vicious circle. Imprisonment exerts no improving influence on the social background of the parents, nor does it promote the welfare of the child who furnished evidence to the satisfaction of the magistrates' court.

Poor law authorities may assume the parental rights of children committed to their care, but seldom is this right invoked in relation to the numbers of children known by health visitors to be ill-cared for and neglected. New ideas in social legislation will have little influence on this problem group, unless a condition is attached to the payment of family allowances, and a minimum standard of hygiene and child nurture be demanded. Parents who prove incapable of achieving this standard should be relieved of the parental rights and allowances.

By a curious anomaly, health visitors do not supervise the welfare of children boarded-out by an education authority, nor do they make the home investigations in cases in which application for an adoption order has been made. These duties are usually undertaken by an officer of the education authority, for whom no special training or standard of qualification is demanded.

The law in this country does not require the notification of pregnancy, but the health visitor makes early contact with many expectant mothers in her area by observation and by the degree of confidence she has achieved.

In addition, the domiciliary midwives service, the ante-natal clinics, maternity homes and maternity departments of municipal hospitals, all function under the central control of the medical office of health. The health visitor is therefore informed from the central officer of the women residing in her area who have made a call on one or other of these services. From whatever source the information is gleaned the approach to an expectant mother needs tact and wisdom.

The health visitor will advise the mother on matters concerning her health, on preparation for the confinement and lactation, and on the organising of domestic affairs and the care of the young children during the confinement period. She will give the mother information on the schemes for maternal welfare, on home helps, short term nursery accommodation for toddlers, compassionate leave and the obtaining of the many priorities which are

available to expectant mothers in consequence of food and clothes rationing.

The unmarried expectant mother and the unfaithful wife are again priorities in interest, and on their behalf many social contacts have to be made.

In the case of the young girl, conflict between the girl and her family, difficulty with landladies, border-line destitution consequent on loss or termination of employment, the anxiety concerning the future of herself and the child, are all problems needing sympathetic treatment. In dealing with these cases health visitors realise the need for more anti-natal hostels, and for a specially adapted scheme of maternal care.

The problems associated with the unfaithful wife, particularly when the husband is on active service, are even more difficult. Reconciliation and the rescue of the marriage are generally aimed at, and the welfare of the unwanted child has to be specially considered. Nursery accommodation for the infant with arrangements for early adoption, and compassionate leave for the husband have proved the best means of dealing with the situation.

In routine surveys the health visitor must be vigilant at all times to observe cases of unregistered fostering, unregistered child adoption, and in tracing the whereabouts of unwanted children. In such cases she may be the sole protector of the child's interests, and no such child may be allowed to just disappear.

In spite of all legislation governing child life, parents still retain their right to give a child away without any regulation, if they so wish. Health visitors are aware of such transactions in which a child has been handed to foster-parents with whom his natural parent or parents had made casual acquaintance, and with no knowledge of the condition of the home into which the child was to be taken. These are the depressing features of a health visitor's work ; but they are counterbalanced by the happy mothers and babies which form her daily acquaintance, and in whom she feels some personal pride.

The standards of a home are determined largely by the ability of the mother in the home, and no one appreciates more than a health visitor how splendidly the majority of mothers accomplish their task.

## The Almoner as a Medico-social Worker

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**Scope of Work :** Although the first Almoner was appointed some fifty years ago, it is only recently that the work has become known to any extent. Even so, there is much misunderstanding as to the real functions of the Almoner, possibly much of the confusion being due to the title which implies the dispensing of alms.

Her real task lies in medical-social work, which may be defined as the art of helping people to achieve the widest measure of health and independence, by means of their own capabilities and the resources of the community. It is work which necessitates a wide knowledge of the social aspect of disease.



of social legislation and of the innumerable agencies which exist for the benefit of the sick and needy. Apart from technical knowledge the work demands a real understanding of people and the difficulties which arise in many walks of life ; a genuine desire to help ; and qualities of initiative and tact.

The Almoner works in close co-operation with the Medical Staff to whom she supplies the picture of the patient's social background and individual problems, in so far as they are relevant to the diagnosis and treatment of their disease. Helping the patient to talk over his difficulties, she enables him to find the best means of carrying out the prescribed treatment, and endeavours to relieve his mind of that undue anxiety which must ultimately retard recovery.

On a patient's discharge from hospital she is responsible for his after-care ; helps to re-establish him in normal life ; and obviates whenever possible those factors likely to lead to a recurrence of his illness. Where recovery is beyond hope, she assists him with whatever aid will ease the burden of suffering and bring comfort to mind and body. Home nursing, loan of such requisites as air pillows and bedrests, financial aid, friendly visiting and admission to hospitals for the dying, are among the many ways in which help can be given at this stage.

The duties of the Almoner vary from one hospital to another according to the size of the department and the amount of scope allotted to it. Broadly speaking her duties may include all or any of the following : Responsibility for the social welfare and after-care of patients in the wards and attending at the various clinics ; sharing in the formation of hospital policy in so far as it affects the welfare of patients ; and acting as a link between the hospital and those social agencies and public authorities concerned in their welfare. The latter usually necessitates attendance at committees and conferences.

More general duties include the planning of convalescence, sanatorium and other forms of residential treatment and the provision of appliances. The Almoner is constantly called upon to take part in medical research by the recording of social data, and in addition to the training of almoner students, is frequently required to give lectures on the social implications of disease to the medical and nursing students.

Many hospitals hold their Almoners responsible for such administrative duties as the assessment of patients' ability to contribute towards the cost of treatment, and even on occasion for the collection of such contributions, for claims under the Road Traffic Acts, and for claims from the hospital contributory schemes. The reason for this is partly due to the fact that it is considered that she can make the most just decision, as having the widest knowledge of patients' individual circumstances and diagnosis, and partly also to the fact that in the small hospital there is no other official or department to which such work could at first sight be deputed. There are unfortunately too many hospitals which consider the appointment of an Almoner for purely medico-social purposes to be an unwarrantable expense.

Where she undertakes such administrative work it should be clearly subsidiary to her main function of medico-social work. On this point, however, many hospital authorities fail to realise their misuse of skilled service, to the infinite loss to their patients and themselves. The ideal arrangement in my opinion is that of the release of the Almoner from all purely administrative duties, other than those which arise in the domestic running of her own department.

Comparatively few hospitals so far, have the vision and enterprise of St. Mary's Hospital, which many years ago, relieved the Almoner of all such work. This was accomplished by the establishment of a Patients' Contributions Office with an Assessment Officer, whose duty it is to assess and collect patients' contributions; deal with the hospital contributory schemes; and with claims under the Road Traffic Acts. All these records are available to the Almoner who has the right to request a reduction where the assessment appears excessive in the light of her further knowledge regarding prognosis.

By this means she gains full knowledge of financial circumstances without having to question the patient, is aware of these when seeing him from the medico-social point of view, and thus more readily gains his confidence. She is also in the position of being able to control excessive assessment or offer, on the part of her patients, without antagonising their confidence, or excessive waste of time in administrative work—time which she needs so urgently if his difficulties are to have a constructive solution.

The Almoner service commenced life—as is to be expected—in the voluntary hospitals, the first appointment being at the Royal Free Hospital in 1895. After the transformation of many Poor Law infirmaries into Public Health hospitals, subsequent to the Local Government Act of 1929, Almoners have been appointed in increasing numbers to the municipal hospitals.

The next step was from Public Health hospital to Public Health department, Almoners being appointed to clinics for venereal diseases, to tuberculosis dispensaries, and to maternity and child welfare clinics. Some local authorities have appointed an Almoner to organise medico-social work throughout the various hospitals and clinics under their jurisdiction, the Chief Almoner being a member to the Public Health staff. Others have amalgamated the duties of social work in a small part-time venereal diseases clinic, with those concerned with the illegitimate children under their care.

Under the Emergency Medical Scheme, brought into being on the outbreak of war in 1939, many additional hospitals were made available for general use, those which had hitherto been utilised as Poor Law institutions, sanatoria or mental hospitals. Known as Base Hospitals and attached with others, to a sector or region of the Ministry of Health, many of these have been staffed by Almoners from the parent hospitals especially where the latter have suffered considerable air raid damage, as a result of which, admissions have had to be diverted to the Base Hospitals. Where this has been impracticable, independent appointments of Almoners to a large number of Base Hospitals has taken place.

Since patients pass between inner and Base Hospitals, the Almoners of both need to work in close co-operation in order that the patient may gain the maximum advantage and in order to prevent overlapping or any break in the continuity of treatment and social care.

It will be apparent that her daily work brings the Almoner into contact with widely divergent problems and groups of people, and that she must of necessity, gain an insight into many of the causes and remedies of social ills. By careful record keeping and observation, she is able to produce revealing information on the social aspects of disease. Yet another of her tasks must therefore lie in her willing agreement to take part in the wider issues affecting her patients and to assist in so far as she is able, in those preliminary conferences and discussions which yield ultimately to the formation of change in policy and to new social legislation.

**Training :** Candidates are selected for training by the Institute of Hospital Almoners, Tavistock House (North), Tavistock Square, W.C. 1, the secretary of which is Miss Steel, to whom all inquiries should be addressed. The conditions of training have been somewhat affected by the demands of war, although the Ministry of Labour recognised from the outset that the work is of national importance and that its continuity depends upon a regular intake of students.

The University course for the non-graduate covers two years, at the end of which the Social Study Certificate or Diploma must be obtained. This includes such subjects as social economics ; industrial history ; social administration ; philosophy and psychology ; while Almoner students are required to have some knowledge of physiology.

Fifteen months' practical work includes four spent in family case-work agencies learning how to visit and interview, and in letter writing and office routine. The other eleven are spent in hospitals both in London and the provinces, working under trained Almoners.

At the successful conclusion of training a certificate is granted, by which the student becomes an Associate of the Institute of Hospital Almoners. Among the many services rendered by the Institute to their Associates is that of maintaining a register of trained Almoners and the circulation of information regarding suitable posts.

**Hospital Work :** By far the greater number of working Almoners are employed in hospitals, which offer a wide variety of posts. In the large teaching hospitals there are usually sufficient Almoners to form a department, the object of which is to enable individual service to be carried into wards and specialised clinics as well as into the out-patient department.

In such hospitals the post of Chief or Senior Almoner carries the responsibility of co-ordinating the work of her assistants, planning duties and deciding policy. She is responsible through the House Governor to her Board of Management, or in a municipal hospital through her Medical Superintendent to the local authority, for all that affects her department. She is available for consultation to any member of her Board or Medical Staff regarding the social aspect of disease.

To her assistants she endeavours to provide variety of experience and the opportunity to develop individual skill. By increasing responsibility she helps them to prepare themselves for senior posts and to undertake these at other hospitals as opportunity occurs. By keeping in touch with the wider issues of the work and with new developments in other professions and in social legislation, she attempts to keep herself alert to any weakness in her own department or to any opportunity for further progress.

The Almoner wishing to specialise in any branch of work gains useful experience in acting as assistant in a special unit of a large general teaching hospital. This helps to prepare her for a senior post in one specialising, for instance, in diseases of the eye ; in tuberculosis and chest conditions ; or among such specialised groups of patients as children or expectant mothers.

The small hospital offers to the single-handed Almoner the satisfaction and happiness of knowing all the patients. The corresponding disadvantage lies in her inability to carry out detailed work, since owing to lack of time, she must continually select the work of greatest importance, handing over to outside agencies much which she would prefer to undertake herself. She

cannot for instance, undertake a great deal of after-care unless she is so fortunate as to acquire skilled voluntary aid.

Municipal hospitals offer a wide variety of posts which depend largely upon the conception of the Almoner's duties formed by the members of the local authority, and the amount of sympathy with her work which is held by the Medical Superintendent of the hospital. Whereas in some, the work is almost entirely administrative, in a few, it is purely medico-social. On the whole it seems fair to say that this side of the work is considerably hampered as yet in most quarters.

**Specialised Work :** In so far as possible, Almoners are discouraged from early or permanent specialisation, since it tends to present an abnormal view of the social background. Everything depends, however, upon the individual, for some of the most able in the profession are among those who have so specialised.

Opportunities for such work occur in hospitals concentrating on certain diseases and in the specialised units of general hospitals. In addition there are clinics for venereal diseases ; tuberculosis dispensaries and sanatoria ; clinics for the treatment of rheumatic conditions ; maternity and child welfare clinics and rehabilitation centres.

Many Almoners interested in mental disease take the special training in mental health and qualify as Psychiatric Social Workers, later taking posts in the Child Guidance clinics and mental hospitals. The Almoner qualification and experience is a useful basis for all forms of social work and is widely recognised as such.

Although in principle the work is similar whatever branch of almoning is adopted, each group of patients has some special need on which emphasis must be placed. In the clinics for venereal diseases patients are drawn from all strata of society and the value of the Almoner is manifold. She is there to gain the confidence of her patients and to overcome their obstacles to treatment. For the married woman she is able to help with the family, with adjustment to treatment and where possible, to a better understanding in the home. Her chief value lies, however, with the single girl, the destitute, the unmarried mother, the hopeless and the outcast.

To all, the Almoner endeavours to extend her friendship and understanding, for curing disease is of little help to these patients without removal of the causes which led to infection. Homes and jobs must be found and the long, weary process of rehabilitation set in progress, by which the will becomes strengthened and self-respect is regained. This demands patience, courage and positive friendship if any real progress is to be gained ; nor must the worker be in any undue haste for results.

With the increase in the incidence of tuberculosis, especially among the younger age groups, the Almoner finds plenty of opportunity for service in this branch of work. Possibly the most trying stage of all is on the patient's discharge from sanatorium (where conditions and life had been regulated entirely to his need and amount of strength), to the home which all too often is crowded and cramped. Finding suitable employment and helping to bridge the gap between the treatment and work are invaluable aids to the patient's recovery. There are many other tasks such as overcoming obstacles to treatment and relieving anxiety of mind, all of which are to be met with in hospital or clinic.

In connection with rehabilitation the Almoner's task is to help men and women learning to face life from a fresh angle and to become accustomed to changed circumstances. Illness or injury necessitates their readjustment to another mode of living, and at each stage the Almoner can do much to help with material and friendly aid. Such work necessitates close co-operation with the officials of the Ministry of Labour as well as with the Medical Staff, since no constructive plan for the future can be made without full knowledge of the patient's social and medical background. Neither will the patient find such plans acceptable unless his confidence has been gained.

**What does the Future Hold?** Whatever form the health service of the future may take, people will remain essentially individual and as such, problems and difficulties will always arise which cannot be solved by legislation. The State may provide for all exigencies in life, but aid is only acceptable in many instances through the human means of kindness and understanding applied to the individual in need.

The service which medical staffs and patients of certain hospitals and clinics are now in a position to demand from their Almoners, should be made available to doctors and patients throughout the country. After-care and rehabilitation are essential adjuncts to the successful treatment of illness if further breakdown is to be avoided. Social care of potential and expectant mothers plays no small part in the campaign for prevention of disease and attainment of positive health.

The hospital and the Health Centre of the future, as indeed the general practitioner also, should have the Almoner service within reach in the same way as other means of help for their patients. By acting in a consultative capacity it should be possible for an Almoner to serve a group of isolated general practitioners and possibly more than one Health Centre. In the congested areas this would doubtless prove impracticable as giving her insufficient time for constructive work. No hospital should be considered efficiently equipped which lacks a trained Almoner on its staff.

To give the maximum amount of help the Almoner needs the understanding and co-operation of the public whom she works so hard to serve. Far too many people still regard her with antagonism or disinterest, as having some vague connection with money. Until they realise her possibilities, the full strength of her ability to help cannot be unleashed. An appointment to the Ministry of Health Staff of a trained Almoner in an advisory capacity would go far to establish this. Through such means the confidence of the public would be more easily gained, the backward authorities more easily encouraged and the general standard of medico-social work maintained.

In the meantime the work continues and those engaged in it are amply repaid for their efforts in the comfort of mind and progress shown by many of their patients, and by the stimulating help and encouragement which is made clear in so many directions.

# Health and Welfare in the Civil Service

SIR HENRY BASHFORD, M.D., F.R.C.P.

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IT should perhaps first be made clear that the Civil Service differs in many respects from most outside industries and business concerns. It is of course the agent of government, normally offering to its entrants a life-time career, with a non-contributory lump sum and pension on retirement—usually at the age of 60—based on years of service. Annual leave is on full pay. Sick pay—always provided that there is a reasonable prospect of recovery to render regular and efficient service in future—is at the rate of full pay for six months, half pay for six months and then, if this has been qualified for, pay at pension rate. All candidates for an established pensionable appointment in the Civil Service are required to undergo a medical examination before acceptance.

As regards the organisation of what may be called staff medical supervision, study of sick absence problems, and welfare, this may be said to have had its first beginnings in the Post Office. Though the Post Office differs largely from the rest of the Civil Service in its work and problems—especially in that it contains very large numbers of indoor and outdoor manual and technical workers, both men and women—it is numerically much the largest Department of the Civil Service and indeed in peacetime embraces more than half of all Civil Servants. About the middle of the last century, it was decided to provide free general medical attention to all the established staff in the Post Office below a certain salary. This was provided at Headquarters by a small whole-time medical staff, under a Chief Medical Officer, and elsewhere throughout the country—including Wales, Scotland, and Northern Ireland—by local general medical practitioners, who held the Post Office appointment in addition to their ordinary work. It was their duty to give the medical attention required, to report if necessary on any other members of the Post Office staff in their areas, to examine local candidates for employment or establishment, and to make an annual report for the Chief Medical Officer upon the sanitation, ventilation and general condition of any Post Office, Telephone Exchange, or other Post Office building in their areas.

This organisation grew, as the Post Office itself grew, until with a Post Office staff of about 250,000 there were some 2,600 local Post Office medical officers co-operating in the work. As a corollary to all this, a system of accurate sick record keeping was established so that any Post Office doctor, asked to report upon any particular officer, could see at a glance, what that officer's past medical history had been. This system also allowed for accurate annual sick rates to be kept for the whole staff, for each chief section of it, and for the staffs in particular cities, towns and districts, enabling useful year by year comparisons to be made.

The Post Office thus became one of the oldest and numerically largest examples of what has since come to be known as Industrial Medicine. The gradual accumulation of tens of thousands of sick records, embracing working

life-times from 14 or 16 to 60, enabled long-distance large-scale observations to be made on the effects upon actual working capacity, of various real or imagined medical disabilities and of various forms of medical and surgical treatment. These observations or "follow-ups" were upon a scale and of a degree of accuracy, as regards practical working-capacity, that were not possible either to hospitals or individual physicians and surgeons. Many of them have been published, to the direct or indirect benefit of workers all over the world, and also to medicine itself. As an example may be quoted the condition of adolescent albuminuria, which was at one time believed to be of such serious import as to render young people suffering from it ineligible for the services, any pensionable employment or even life insurance. Long-distance, large-scale observations helped to establish finally the relative unimportance of this condition, and to lift a quite unnecessary handicap from very many young shoulders. As another example may be quoted the Post Office observed experience of healthy "contacts" with most of the common infectious fevers. This led to the abandonment many years ago of what has proved to be a wholly unnecessary and wasteful system of quarantine.

But the regular, routine supervision of sick absence records, year in and year out, also brought to light many individual cases of prolonged or excessively numerous minor or vague illnesses. In a number of these it was found that some physical disability, such as infected teeth and tonsils, was the underlying cause. But in many others the basic trouble was psychological—a real or imagined grievance, dislike or fear of some particular duty, or some personal antagonism or domestic worry. In many of these it was found possible to suggest a solution such as a change of duty or a transfer to some other office or place. Even the mere unburdening of the anxiety often had an almost dramatic effect, with an immediate improvement in attendance, health and efficiency.

Incidentally it also led to an appreciation of the immense influence of lay supervision in creating or dictating the "atmosphere" of an office or Department, and the fundamental importance of securing the right sort of supervisors or heads of departments—men and women, technically capable, but also healthy, sympathetic, approachable and with the golden quality of knowing when to be blind at the right moment. As an illustration of this, the following figures are appended in respect of five groups of men and women all working in the same office.

#### AVERAGE ANNUAL SICK ABSENCE IN DAYS

		MEN			WOMEN	
1st year ..	..	15.0	15.4	14.7	24.5	25.8
2nd year ..	..	16.7	14.1	23.5	35.1	39.8

#### CHANGE OF LAY SUPERVISION

3rd year ..	..	8.0	6.9	13.2	22.1	12.9
4th year ..	..	7.0	7.3	13.0	14.3	10.7

It is not claimed that the change of lay supervision was the sole factor in this reduction of sick absence. But it was undoubtedly the principal one—the conversion of the office into what the sailors call a "happy ship."

Although free medical attention to all below a certain salary has not been extended beyond the Post Office, this system of regular routine supervision or study of sick absence has recently been enlarged to cover all the other Departments of the Civil Service. A uniform method of sick record keeping has been established throughout the Civil Service, and a uniform method of reference of all sick records showing a certain degree of abnormality. Outside the Post Office and one or two other Departments which have their own permanent whole-time medical officers, these are all referred to the Treasury Medical Adviser and his assistants. A uniform system of recording all cases of pulmonary tuberculosis has also been established, with regular progress reports, and all cases of medically certificated illness suggesting conditions of particular risk are also automatically referred by every Department for medical advice.

It is this accurate keeping of sick records, their regular routine reference, and the day by day efforts to adjust the square pegs to the square holes that constitutes, in the present writer's opinion, the essential and most valuable basis of all industrial medicine. But this is not to deprecate the very great importance of actual physical environment—adequate lighting, heating, ventilation and an appropriate scheme of colour decoration to the particular office or particular work being done in it. A good deal has been done in all these matters, but a great deal more awaits the end of the war and the release of necessary materials and labour. This also applies to rest-rooms, sick-bays for transient indispositions, and refreshment rooms. As regards leisure, hobbies and games, the Civil Service is fortunate in already containing in most of its Departments experts and enthusiasts in the various arts and sports, and many intra-Civil Service societies devoted to these are in existence, if temporarily in abeyance. But it will be one of the post-war tasks, with the assistance of welfare officers and others, to get these going again and arrange for their extension.

More difficult to deal with, but a problem that must somehow be solved, is that of monotony and necessarily uninteresting work—and this applies not only to the Civil Service but to industry generally. It is a constant feature of Civil Service sick rates that these are very much lower in the groups engaged upon responsible and "brain-stretching" work, than in the groups employed upon more routine work, often demanding a high degree of accuracy but of no essential particular interest. It is proved experience that people engaged in such work find it more difficult to ignore or disregard minor ailments, and the work itself is probably more likely to induce a pre-illness condition of fatigue.

In a brief summary such as this, it is not possible to do more than give a general outline of the aims and methods of this Staff medical service in Civil Service Departments. But a word or two should perhaps be said about First Aid services. Here again the Post Office, with its large sorting offices, mail services, engineering factories and workshops, more nearly approximates outside industry than do the other mainly clerical and administrative Departments of the Civil Service. But the Post Office has long had a very strong and enthusiastic voluntary First Aid movement under the ægis of the St. John Ambulance Association, and its Post Office Ambulance Centre, with many branches in London and a certain number in the provinces, is one of the largest in the country. Before the war, lectures were regularly given by the medical men and women attached to the Post Office and annual



competitions were held. There were also strong Post Office uniformed divisions of the St. John Ambulance Brigade and Nursing Division, consisting of men and women willing to do outside First-Aid work in their spare time. This movement has received the fullest encouragement from the Department and, at the beginning of the war, proved of the utmost value as an already existing nucleus of trained men and women, able to act as instructors for the hundreds of volunteers required to meet possible emergencies due to enemy action.

As regards whole-time welfare officers, whether men or women, Civil Service conditions as a rule, are very different, both in respect of work and labour, than those in most outside industries, factories and workshops, and not many such were to be found in the Civil Service before the war. During the war, however, with particular new problems of evacuation and billeting and the creation of certain wartime Departments largely staffed with temporary employees, welfare officers have definitely proved their value. In what particular fields or to what extent they should play a part in the Civil Service under normal peacetime conditions, remains to be seen and is now under careful consideration. Finally a word might, perhaps, be said on an interesting development in the way of convalescent homes which began in the Post Office a few years before the war. As the result of what was primarily a staff movement, with official sympathy and support and upon a voluntary membership basis and a small weekly subscription, two fairly large country houses, with ample surrounding grounds, were acquired, one in Wales and one in Scotland. They were well and tastefully furnished and every subscriber was entitled, on a medical certificate, to a convalescent period of two or three weeks free of charge. Further, every subscriber was entitled to take a holiday there, as and when beds allowed, for a relatively moderate weekly charge for food and lodging. There were literally no rules and, in spite of some initial misgivings, thanks to the tact and ability of the matrons, the general atmosphere of the two places, and the co-operation and commonsense of all concerned, none have proved to be necessary. The combination of convalescent and healthy holiday-makers, the mixture of officers and their wives and families of all ranks, and the complete absence of any sort of "institutionalism," have had the happiest psychological effects, and the experiment has shown itself not only to be very popular but financially sound. Here too is a movement with possibilities of future extension.

## The Day Nursery

ETHEL CASSIE, O.B.E., M.D., D.P.H.

THE day nursery is the oldest of the institutions we now think of as part of a child welfare scheme. It was the outcome of the industrial revolution and low wages. To live at all the whole family had to work, including the mother. Dr. McCleary in his useful little book, *The Early History of the Child Welfare Movement*, states that the first crèche was opened in France in 1844, and many others followed in the industrial areas. In England, however, the "daily minder" and the ordinary infant school sufficed for many years,

till it was eventually realised that something should be done to help the children of women forced to leave their homes to work. The Manchester and Salford Association of Voluntary Workers, already the leaders in attempts to help mothers and babies, opened the first of the early day nurseries in the 1880's.

Even in the largest cities very few day nurseries were available till the last great war, when the pressure on man and woman power led to appeals to married women to return to the factories. To allow them to do so, various simple forms of day nurseries were opened in the industrial cities. This was done mainly by voluntary agencies, but in 1919 there were 32 municipal day nurseries at work.

After the war many nurseries were closed, and in 1938 a great industrial city like Birmingham had no day nursery. The number in England and Wales in that year was 104, and of these 83 were the responsibility of voluntary agencies. This number was quite unrelated to the number of women working in factories, and the number of children the nurseries could deal with was only 4,291. The fact is that a day nursery is an expensive institution, the mothers' payments barely covering the cost of food, which is only a fraction of the total cost. Few nurseries escaped financial difficulties, and standards were often low. However, here and there better types were evolved, thanks to farsighted committees and generous helpers. Lay committees appear to find it difficult to understand why looking after "well" children for ten hours out of the 24 should be so costly. The amount of time and trouble given by the individual mother to the individual child, where the child is well cared for, is never realised. It is a labour of love given ungrudgingly over a 24 hour day. A staff of one to three is reasonable in a nursery, while everything a baby requires—light, ventilation, warmth, cleanliness—is expensive. The right food means expensive food, such as milk, eggs, fruit and fats. The overhead charges are heavy. The right type of building in the right place with an open space round it, is not easy to find in an industrial city. Building is costly. It is not surprising that so few day nurseries existed, or that so few were first class.

At the beginning of this war when labour was again required badly, the demand for married women to return to the factories became insistent, and by 1940 it was clamorous. Finally the Government decided that day nurseries must be opened in all industrial areas, and with this decision came the realisation of what day nurseries mean in cost and staffing. It is probable that very few women are actually released for the labour market by the use of day nurseries, but the factory manager had no doubt that the women released were wanted. They were women trained in their youth to factory and mechanical routine; they were older and more responsible workers. Younger girls staffing the nurseries were not the type who would enter factories, and the older women who formed the "child care reserve" to work in nurseries, would have been of little use to the industrialist.

As the drive for nurseries went on, costs, as in all war emergencies, became unimportant. Great feats of organisation were carried through, and in 1944 no less than 1,555 nurseries—accommodating 72,120 children—were at work.

However, there were many who felt strongly that these measures were unjustifiable from the child welfare point of view. It was feared that the new nurseries would be hot-beds of infection, and that the children would suffer psychologically. In consequence, a high standard for the older

children—including kindergarten methods—was established from the first.

It is impossible to discuss here the many complicated problems involved in opening the nurseries. The various schemes for obtaining and training staff necessitated a vast organisation, from which much has been learnt. The supply of premises and equipment in wartime was managed most efficiently in view of all the difficulties, which at times seemed insuperable. The whole story is a fascinating one. The success of the effort is proved by the satisfaction of the mothers and the good results obtained for the children.

An outline of the organisation of nurseries is all that can be attempted, and will be in the main a discussion of some of the problems involved.

### **Grouping Children in Nurseries**

The children fall into four groups, but are usually formed into three for convenience. It will be understood that only children up to the age of five are admitted. The groups are :

1. Babies, under nine months.
2. Tweenies, from nine to eighteen months.
3. Little toddlers, eighteen months to two and a half years.
4. Toddlers, two and a half to five years. Groups 2 and 3 are usually combined.

**Babies :** This group is the easiest managed given skilled supervision. Trained nurses if not already familiar with baby nursing, readily acquire the technique. Speaking generally the babies do very well in nurseries.

**Tweenies and Little Toddlers :** This is universally agreed to be the most difficult section. Admitted as babies and continuing in the nursery, the difficulty is minimised but still exists. Coming to the nursery for the first time at this age, the children miss the individual attention of the home, not as regards food and cleanliness, but as to "being taken notice of." It is impossible to give them the handling, the petting, and the immediate attention to every reaction they get in any reasonably good home. They are miserable, fretful, refuse food, and often lose weight. It is extraordinary how skilled some nurses are in managing what is really a difficult situation. Such a nurse will have eyes everywhere. A little extra petting here, a little distraction there, and gradually the child settles down. But how rare these nurses are. They must be sought and recognised as pearls of great price.

The tweenie is still in the cot and play pen, or at the crawling stage. The little toddler is an independent but detached individual. He is not interested to any extent in his fellow toddlers. They are to him furnishings of the nursery. The child can play by himself now for short periods, but still requires intensive attention and individual training. Food habits are important and he must be taught how to handle his implements and to feed himself. There can be no reduction of staff at this period. In fact one nurse to two children, allowing for "off-duty time" is by no means too much. The age grouping must not be too rigid, since development proceeds in an individual fashion. It is an advantage to have "over twos" among the small toddlers, to teach the others and to encourage the art of talking. Children reach various developmental stages between two and three. Few are really interested in group activities till two and a half. A slow progress

child should remain with the younger group longer, but at three children should have reached the kindergarten stage.

**The Toddler :** There is little difference here between the day nursery and the nursery school, except in the hours they are available. For the mother working in the factory the usual nursery school hours are too short. It is not only a question of getting to and from work, but there is shopping and getting the home clean and warm. The nursery school opening from nine to four makes it difficult for the mother without a convenient relative or friend. The day nursery with a nursery school section meets the problem, and also allows a younger child to be brought to the same institution.

### Premises

These must be adapted to allow of grouping. The hutted nurseries supplied by the Ministry of Health have been excellent, particularly because they are single storied buildings easily accessible to a garden or playground.

**The Babies' Nursery :** Preferably the nursery must have a separate bathing and changing room off it. All sluicing must be done quite apart, if possible in an outbuilding. The danger of faecal infection must never be forgotten ; each child must be treated as a unit. A nurse's gown hangs by each baby's cot, and should be worn when the baby is changed. The routine of washing the hands after replacing the baby in the cot is a safeguard for the nurse as well as for the next baby. Enteric infections among young nurses are one of the bugbears of nursery staffing.

A special kitchenette for baby feeding with a refrigerator should be provided.

**The Tweenies and Small Toddlers :** In the hutted nurseries the one large nursery is provided for these groups. A greater floor space is required here, since large cots must be available as well as play pens and tables for meals. The bathroom with small lavatories must be near by, but should not open off the nursery as the danger of infection is still greater at this age, particularly from dust. Low hand basins will make it easier to teach the children to wash their hands after using the lavatories, but an adult hand basin is also required for the use of the staff. The use of individual towels for each child is as important as ever, for impetigo is an ever present menace.

**The Toddlers :** This group requires a really large room arranged as a nursery school with the usual cloak room accommodation.

Floor space is important. The Ministry of Health has laid down the following minimum dimensions : 35 square feet per infant, 30 square feet per tweenie, and 21 square feet per toddler. The amount allowed for the tweenies is rather cramped. Since floor space determines the numbers this must be the earliest consideration, a point often overlooked by the inexperienced enthusiast.

Accommodation required includes a small laundry and drying room, a kitchen from which the food can easily be served, a staff dining room and cloak room, and a matron's office. This last should be in close proximity to a reception room, where the mothers leave and receive the children. Too often this is nothing but a passage.

The largest number requiring admission is usually in the tweenie group. Women, if they can help it, will not go to work as long as their infants are much under a year old. Relatives and friends are more ready to deal with the older toddler, but no one wants the exacting and troublesome tweenie or small toddler. The number of older toddlers can be fixed by the number one trained teacher can manage—about 20. The babies will seldom exceed ten, and the remaining places (30 in a 60 place unit) will be readily occupied by the 2nd and 3rd groups. This is a satisfactory size though larger and smaller nurseries are frequent.

### **Staffing**

It is now very generally agreed that the matron should be a state registered nurse. She should have had a special course covering children's infections, dietetics, and staff control. A sister, or assistant matron with similar qualifications, is also required to act as relief. A school teacher will take charge of the toddlers. With staff nurses and probationers the staff usually required is one to three children. But this will depend on the hours the nursery is open and the actual work done in the nursery, such as laundry, cooking, mending, etc.

### **Hours**

In wartime nurseries children are only admitted when their mothers are doing full-time work. Such work covers varying hours. Factories often work three shifts, and transport workers are on duty late or early. For some a "24-hour nursery" is essential, but with the help of relatives and neighbours, the majority can be fitted in between 7.30 a.m. and 7.30 p.m. Most children arrive before 8.30 a.m. and leave before 6 p.m. It is essential to avoid overworking the staff, otherwise the sickness rate rises rapidly.

### **Central Laundries and Kitchens**

In nurseries which are more or less isolated units both laundry and cooking are done on the premises. It is inevitable that some washing must be done in this way, or very large reserve stocks must be carried. Probationers must be given lessons in laundry work. Much the same thing applies to cooking. For a large authority managing a number of nurseries, possibly 20 or more, a central kitchen is worth considering. Ready cooked vegetables are a difficulty, these can be sent out prepared but not cooked. A central laundry has many advantages and is an economy if properly managed.

### **Clothing**

It is customary to supply staff uniforms, and overalls for tweenies and toddlers, as well as changes of underclothing for the former. Some baby clothing must be available too. In the past it was often necessary to change the infants and tweenies completely on arrival, as the clothing was often so unsatisfactory and dirty. The standard, however, has risen in the last twenty years, and with high wartime wages it has been possible to demand better clothing for the children. At the same time some comment is called for on the extremely unsatisfactory clothing available for the children of the poor. Good ready-made clothing is very expensive. What can be afforded by the working woman is of very poor quality indeed. After two or three

weeks wear it is of little further use, and in any event it is seldom warm or windproof. There is here a real field for helping mothers. Children's utility garments of a good standard and at a reasonable price should be made available under a control scheme.

### **General Routine**

A good nursery routine with as much time out of doors and as much activity as possible, with suitable rest periods, should be the aim. It is not possible to discuss this in further detail, or to enter into particulars of the diet. Trained medical supervision is required.

### **Infectious Diseases**

Medical officers of health have always feared day nurseries as hot-beds of infection. These fears have been somewhat exaggerated in view of the other contacts between children. There can be no doubt, however, that infections make nurseries tiresome institutions to administer. There are three types of infection to deal with, epidemic disease, catarrhs, and skin diseases.

Epidemic disease falls into two groups, the common infectious fevers normally spread by schools, street play and transport, and the conditions spread by faecal contamination. One administrative problem is that the mother must remain at home to nurse the child when he falls a victim. He will of course be excluded from the nursery with all the family contacts who have not had an authentic attack of the disease. It is possible for the local authority to admit the affected child to an infectious disease hospital, if there is enough suitable accommodation. Another useful arrangement is the provision of a resident "sick bay" for mild infections. To this, contacts can also be admitted in special ward groups. A second problem is the high percentage of probationers who pick up the infectious fevers particularly measles, german measles, and mumps. When nurses are victims staff difficulties become acute. Catarrhal jaundice, which is always a problem in children's institutions as far as nurses are concerned, has been a major difficulty in wartime nurseries. Adolescents and adults are more seriously affected, and are left debilitated for a much longer period than young children, who frequently have only a few days mild enteritis, with very slight, if any, jaundice. Dysentery of a mild type has also been common in the nurseries. The exclusion of carriers and the consequent depletion of staff leads to difficulties. The importance of early medical diagnosis must be stressed, and all nurseries should have a doctor on call to see a sick child. The danger of overlooking diphtheria and scarlet fever must not be forgotten.

The avoidance of faecal infection is important. All diaper sluicing should be done in an outbuilding, in a sluice room where special gowns and masks are worn. Suitable equipment must be provided to diminish handling. A spray and long-handled brush are required. Nurses doing this work must "scrub up" in the surgical sense before eating or preparing food. The nurse's personal hygiene is all important, and should be the first lesson taught to the young probationer. Dust is a frequent source of infection and oily mops and dusters are useful.

Catarrhs are always with us in homes, nurseries, and schools. It is difficult to prove they are more prevalent in one than another. It is only a severe cold which is noticed at home, but in the nursery every case is noted.

To tell a mother not to bring a child if he has a cold is impossible in wartime nurseries, it would mean absenteeism from war work. Isolation rooms and bed isolation help.

It is fortunate that so many skin diseases such as eczema and seborrhoea are not contagious, since the spread of impetigo, ringworm and scabies, if neglected, are quite sufficiently troublesome. The word neglect is operative, for with careful observation and a good routine, skin diseases should be easily managed. For these conditions a resident "sick bay" is particularly useful.

### **The Post-War Nursery**

The link between the nursery and industry has been strengthened by our wartime experience. There can be little doubt that many women will wish to remain at work, and that nurseries can help them to do so with a minimum of disadvantage to their children. We do not know to what extent this demand will continue. It depends possibly on the mobilisation of labour for reconstruction.

The day nursery can play another part however. Mothers, like other women, require periods of rest and recreation, and time for shopping and social contacts. The nursery as a "part-time" institution for individual children can give mothers "half-days" off. There seems to be no reason why they should not be so used. The nursery schools will not be sufficient alone, even when widely established, since they do not deal with the youngest children. The burden on the mother of continuous care and supervision of young children is one of the factors reducing the size of families. The very natural wish to enjoy social life together affects both husband and wife. This aspect of nursery work brings fresh problems, particularly the free week-end and evening. If factories could give a free whole day a fortnight instead of the universal Saturday afternoon, the whole recreational problem would be simplified, bringing Monday as well as Saturday into the picture, as well as the trades' mid-week half holiday. As to evenings no child welfare worker can contemplate evening nurseries with any complacency. In the U.S.A. "sitters up" have been organised among high-school girls—an idea with possibilities among older women, for our consideration. Week-end resident nurseries might be practical, especially where the child is already accustomed to half-days in the institution.

### **Conclusion**

It will be agreed that the nurseries have done valuable war work, and that the children have benefited. Much has been learnt as to the group care of children, and the education and training of staff. While young children do best of all in their own homes, if they are good homes, the day nursery is a satisfactory second best. It will probably always have its place in our social economy.

# Family Allowances and the Provision of School Meals

F. LE GROS CLARK, M.A.

WHILE he was introducing the second reading of the Family Allowances Bill on 8th March, 1945, Sir William Jowitt remarked that the House should consider it "not in isolation, but in its complete setting with ante-natal services, maternity services, child welfare, school meals and national health services. There remains a gap, and this gap can only be filled by cash payments to be made without a contribution and without a means test." Now, this theory of the "gap" may be the best and perhaps the final argument advanced in favour of a system of family allowances. But the fact that the allowance scheme and the school meals scheme were associated within a single measure, raises two important points. It means, in the first place, the attempted fusion of two currents of social reform, that have hitherto tended to develop along distinct and often conflicting lines; and, in the second place, it creates a number of administrative problems, that can only be solved in practice.

**Emergence of the Schemes :** We must first examine how the schemes originated. The proposal to provide meals in school, whether free or on payment, dates back in this country as far as the 'eighties of the last century, though in France it emerged even earlier. It was not, however, until 1906 that an Act was passed enabling local education authorities to provide meals, but only on school days and only to the limit of a  $\frac{1}{2}d.$  on the rates. The number of children benefiting under this Act was at no time very large. Shortly before the outbreak of war in 1914, a few of the more influential of the authorities, who had been faced with periods of industrial depression, urged that the limiting clauses should be removed, and on the day of the declaration of war an amending Act received its third reading in the House of Commons. It was no doubt hurried through its final stages by the Government's fear of industrial dislocation, and in fact, the proportion of children provided with meals rose slightly during the first four months of the war. But from then onwards it fell again, until by 1918 the numbers fed at school were insignificant.

The notion of a cash payment only came into serious discussion at the end of the war. A few writers had touched upon the proposal in the years before the war, but it was in 1917 or thereabouts, that it became at last the accepted programme of a committee of social reformers. The soil from which the movement sprang was partly feminist. It was argued that society ought to recognise by a system of cash payments the productive work of the married woman, and it was further thought that the claims of women in industry for equal pay with men would be assisted, if the married women were encouraged by a cash payment to keep out of the labour market. The members of the original Family Endowment Committee were obviously impressed by both these arguments, but they were almost equally impressed by the benefit of the separation allowances to the families of men in the armed forces. The result of these allowances, it was stated, was that "multitudes



of homes are better furnished and multitudes of children are better nourished than they were in peace." Whether or no they were justified in this belief in 1917, it is clear at all events that they were basing their demands on much the same arguments as are used to-day.

**Social Bearing of the Schemes :** It seems improbable that measures such as these would have been widely advocated before the period of growing industrial concentration, that characterised the first quarter of the century. They coincided, moreover, with phases of war. The earliest recognition by the State that school meals might possibly be a wise provision, was preceded by a lengthy discussion on the physical and education standards of recruits during the South African War, and some grave fears were expressed about the quality of the nation's physique. This mood of disquiet, accentuated once again by the experience of war, was reflected later in the passing of the Maternity and Child Welfare Act of 1918. In the promotion of these and other measures the labour movement played a significant part. While many of its members, and especially those in the leadership of the Trade Unions, were not unaware of the alternative solution offered by a scheme of family allowances, they preferred to turn their attention mainly to the expansion of the direct services in kind. It was indeed the critical attitude of the Trade Unions toward the principle of family allowances, that led to the emergence of two distinct and almost contradictory schools of thought upon the subject. No doubt many men resisted for psychological reasons the proposal that an allowance should be paid directly and specifically to their wives. But the main basis of criticism, to several of the Unions, was the fact that such allowances, if paid by individual firms or from the resources of a pool of firms, would tend to discriminate against the married men with families. They would, moreover, imply a system of unequal wage rates among workers of the same status, and might thus weaken the loyalty of the employees to their own organisations in any dispute upon wage levels. It was felt that the principle of expanding direct services in kind was open to no such criticism. The gradual development of family endowment schemes in France, Belgium and Australia, only partially affected the attitude of several of the larger Unions, and though some of the Labour economists began at last to accept the principle, they invariably made the proviso that any cash payment scheme introduced must be non-contributory and must be met out of the resources of taxation.

To some extent, it must be admitted, the advocates of family allowances had invited this type of criticism by failing to make their own position absolutely clear. They were prepared to adopt almost any argument that might support their campaign, and while they were already gaining by the late 'thirties some influential backing in both Houses of Parliament, several of their new supporters seemed ready to favour a contributory scheme. The Trade Unions, on the other hand, were not likely to be impressed by the new argument based on the fear of a declining birthrate, and the result of it all was, that the family allowance campaign became more and more closely identified with a section of Liberal thought, and began to base its appeals upon the urgent necessity that we should not through indiscriminate use of the social services, weaken the moral fibre of the self-respecting parent. The cash payment, it was suggested, would give the parents a greater measure of responsibility. This view of the matter, it may be said, is still commonly

held among the higher income groups of our own country, and the mover of the Bill was perhaps sensitive to it, when he commented that "our object in this Bill is not to take over the responsibility of parents, or indeed to filch from parents in the smallest degree the responsibility that must remain theirs." Whether or no the Government's proposals were so designed as to satisfy all parties, they have succeeded in doing so to the extent that the allowance is to be non-contributory and is to be paid without a means test. The only problem of primary importance, upon which there has been no basis of agreement, is the exact sum that shall be allowed and the number of children who shall benefit.

### **Wartime Expansion in the Provision of Meals**

By September of 1944, when the White Paper on Social Insurance was published, the extension of school meals had become an accepted part of our wartime economy. It was tacitly assumed in educational circles that school meals on a comprehensive scale had "come to stay." We may note that the distinction between solid meals and the provision of milk, was first made in the late 'twenties. Before that period a few of the authorities had adopted the plan of providing milk to under-nourished scholars. But from then onward, and ultimately through the stage of the Milk in Schools Act of 1934, milk was recognised as an alternative method of supplying supplementary nourishment to school-children. The provision of solid meals, on the other hand, never extended beyond a minute proportion of the children, even during such critical periods as the Mines' Disputes of 1921 and 1926. In the late 'thirties however, the number of meals began to rise slowly and were probably being supplied by the summer of 1939 to some 3.5 per cent. of elementary schoolchildren. But most of these children were a sample of the worst nourished masses of the industrial towns. They were usually in receipt of free meals, and they were frequently being served with them in "feeding centres," where neither the accommodation nor the dietary were matters of primary consideration. The service was, in fact, still oppressed by the shadow of a prevailing Poor Law atmosphere, from which in many of the areas there seemed no immediate prospect of relief.

The development of the service during the war years is a matter of recent history. When the Minister of Food incorporated the principle of school meals into his total war economy in the summer of 1940, he was doubtless influenced by a desire to prepare against an emergency, as it might be necessary to provide communal meals for a large proportion of children or even of adults. But we must appreciate that for the Ministry of Education, the provision of meals had always been essentially a part of the educational process of the child's life. It might incidentally be a form of relief to the ill-nourished, but the Ministry had from the early days of the service, insisted upon the distinction between relief in general, and the maintenance of children found specifically to be unable through lack of food to take advantage of their education. Moreover, the annual reports of the School Medical Officers had never failed to insist that the service had a social and educational value, apart altogether from its dietetic aspect.

There was thus, from the late months of 1940, an increasing tendency to urge the schemes upon the authorities, not merely as a wartime expedient, but as a social reform likely to possess some quality of permanence. It is

true that progress was not so rapid as was at one time anticipated. Several factors are responsible for this, the more obdurate being naturally the "bottle-necks" of accommodation, equipment and labour supply. But by the close of 1944 about 35 per cent. of children in average attendance were benefiting under the scheme. The figures for the provision of milk, which appeared before the war to have stabilised at little above 50 per cent. of possible beneficiaries, rose after a decline in the first year of the war, and have subsequently stabilised again around a level of 75-80 per cent.

The level of demand for meals and milk, if both services are made free, must remain at present a matter of conjecture. A few areas have reached a percentage of 90 or so in their milk provision, and several have already passed the 50 per cent. mark in their provision of meals. The Ministry of Education has established an arbitrary level of 75 per cent. in making its estimates for meals, and apparently from its published figures it assumes that a level of about 90 per cent. will be reached in the demand for milk. The latter estimate is more readily supportable, though there has been no survey to indicate what factors are at work in stabilising the present demand at 75-80 per cent. The demand for meals is more likely to be influenced by prevailing social customs, and the trends in custom can only manifest themselves over a period of time when the country has returned to its normal habits of life.

### **Problems Implicit in the Act**

When the Social Security proposals of Sir William Beveridge were first debated in the House of Commons, the provision in kind through a school meals service, was explicitly related by the Government spokesmen to the principle of the provision of a money grant, and it then became apparent that the two schemes were associated in the discussions presumed to be taking place in the Treasury. The subsequent process of policy formulation has not been revealed, but a few deductions can be made. The Ministry of Education would undoubtedly have persuaded the Treasury that the meal scheme was to be a permanent institution. But no degree of manipulation of the figures could possibly have converted the price of the meals into an arguable addition to an allowance of 5s. the sum usually adopted as a basis for the family allowance. The meals would have to be available for all children, not merely for the second and subsequent children, and above all, while the cost of the food alone might be estimated as 4d. or 5d. a meal, the total cost to the State could not be less than 9d. or 10d. The cost of milk would vary in accordance with the changing market price and the agreements reached with the industry.

But unless the cash allowance was to be related, as Beveridge had related it, to a standard of human requirements, some effort would have to be made to present the two forms of provision as supplementary, the one to the other.

Discussions were still, we must suppose, proceeding at the Treasury level, when in 1943 the new Education Bill was published. As a consequence the Bill had to leave the clause on meal provision somewhat indefinite, and the debates that followed only clarified it to the extent of delimiting the duties of the teaching staffs at meal times, to the supervision of children. In effect, the meals service, as far as the Ministry of Education is concerned, will develop independently, without regard to any temporary relationship it may

have come to possess, to a scheme of cash allowances. The sole problem that might disturb the Ministry, is that of the precise timing of its measures in their bearing upon the time schedule established for the introduction of family allowances. Theoretically every child should find a daily meal available by the time this provision is supplemented, in the case of certain children, by the weekly 5s. allowance. At present no date has been announced for the introduction of the scheme of allowances, and while on the one hand a period of two or three years might elapse before it can mature, on the other hand the release of men from the armed forces might well persuade the Government to hasten its plans.

There will be no administrative hindrance to the conversion of milk provision into a free service as soon as Government policy demands it. Provision of meals up to the 75 per cent. level proposed will obviously take longer. Under the original scheme of school meals the authority was, in a sense, the unit of service, and an authority might claim to be applying the Act if it was providing meals in no more than three or four of its schools. Under the new conditions the unit is patently the school. Every school will have to be equipped with adequate accommodation, and in many instances with a trained staff. The service must be so conceived as to impress the mind of the self-respecting parent and teacher. Even with a reasonable allocation of labour, it is unlikely that the Ministry can complete its programme within a space of three or four years. When it is completed, the annual charge on the country will be one of approximately £60,000,000, of which possibly a fifth might be expended on the provision of milk.

**Conclusion :** We may safely return to the theory of the "gap" in the social services, as the best argument for a scheme of family allowances. The food and other provision made in schools, day nurseries, welfare centres and so forth—either free or at low cost—must be available to all consumers who fall within a certain category. The relative size of a family, which is the citizen's private affair, cannot be assessed in deciding whether a child shall or shall not benefit. Yet families do vary in size, and the evidence suggests that the main cause of poverty among children is the fact that they may be members of large growing families. Unless we are to distribute clothing, footwear and supplementary food among such families, we can only have recourse to a cash payment, which has at least the advantage of being a neutral method of closing the gap. All the other arguments in favour of the measure may be dismissed as irrelevant. If the mother is the sole recipient of the payment, it will possibly affect her status ; if the allowance is sufficiently attractive, it will possibly affect the birth-rate. These are matters for surmise. What is beyond question is that the measure forms part of a general scheme of social assurance, and that no way of dealing with the large family of an employed parent will satisfy the modern conscience save the medium of a cash payment. In brief, if the problem is to be solved at all, it can only be solved by this device.

The school meals scheme will meanwhile follow its own course of development, unaffected by the scheme for family allowances, with which it has temporarily been associated. A few administrative difficulties may arise, as must always be the case where two schemes of very diverse origin and substance, are somehow related to one another in the public mind. But these difficulties, as I have said, are mainly a matter of timing. The most

urgent of the social problems, that will result from an extension of the service to 75 per cent. or more, of the schoolchildren, is paradoxically concerned with their dietetic welfare. Only on the assumption that their home diet supplies all the nutrients they require over and above those supplied in the school meals, can we be sure that the provision of food in the school will be as beneficial as we expect it to be. But that, of course, depends on the measures we take to instruct the mothers of the country in the elements of right feeding. The evidence of a growing social concern for the well-being of the children, is usually itself an educative influence upon the minds of parents and a healthy soil for the cultivation of new values and standards.

## Care of the Eyes in Home and Factory

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**M**ANY visual handicaps and disabling eye diseases could be prevented or alleviated were it not for the ignorance of the public on practically everything connected with ophthalmology. This is perhaps inevitable in so complicated and specialised a subject, but certain broad guiding principles can be laid down, which, if remembered, may help in dealing with both injuries and diseases of the eye when they arise, either in the family or in the workshop.

Life can be divided into three periods ; that of childhood, that of active work and that of old age. Each of these carries with it certain eye risks and these will now be considered on broad lines. For technical points and for detail naturally a comprehensive text book should be consulted.

**1. Care of the eyes of children :** A baby at birth does not see clearly and cannot control the movements of its eyes as an adult can. Clear sight and controlled eye movements develop gradually within the first six to nine months of life. After that a child should be able to turn both its eyes together towards any object, and to focus clearly at any distance from the horizon to a point a few inches from its eyes. Apart from inflammations and gross malformations easily recognised at birth, the first serious eye defect usually apparent to the parents is squint. By squint is meant a condition in which only one eye is turned towards the object looked at, the other being out of alignment and appearing to look at something else. This condition often arises if the child is excessively long sighted and is having to make too great an effort to focus on near things. It follows that a young baby should not be shown objects held close to its eyes, nor have very bright lights flashed at it or dangling toys hung up just over its cot. Avoid trying to show things to a baby until it is able to walk and talk. If a squint is noticed, even if intermittent, in children over nine months, medical advice should be sought at once, since if allowed to persist, squint usually leads to partial blindness in one eye which may be impossible to cure later on. The treatment is

usually a long one but with perseverance the sight can be saved and the squint cured in nearly all cases if treated early.

As the baby grows and approaches school age, the question of when to teach it to read arises. Children of four can be taught their alphabet, using large clear letters, since mentally they are capable of learning it, but they should not be encouraged to read or to do very fine work (*e.g.*, threading tiny beads or trying to sew) for several years after this. It is probable that full capacity of the eyes for prolonged close work is not acquired till the age of seven or eight.

During school years various defects of sight due to abnormal rates of growth of the eyes may appear. These are called errors of refraction, and the common ones are long and short sight and astigmatism. Short sight is often thought to be worsened in predisposed children by illness, by excessive close work in a bad light and by lack of exercise, fresh air and good food. Periodic tests of the eye should, therefore, be carried out during the school years and these are in most schools arranged by the school authorities, who also provide clinics for treatment and for the provision of glasses. Each child should be tested three times during the school years. Remember that a child hardly ever complains of defective sight as he does not know how well he is supposed to see.

Children of ten develop infections of the edges of the eyelids, and of the thin membrane (conjunctiva) covering the front of the eye. If the lids become inflamed and discharge appears sticking to the eyelashes, the advice of a doctor should be sought unless the condition clears up in a week, since if neglected it may lead to lifelong trouble. This disease (blepharitis) often follows measles or some other illness, and is extremely intractable if it is allowed to become chronic.

If the eye becomes bloodshot (conjunctivitis) advice should be sought, as this condition is very infectious and may run through a school or a family, thus causing great discomfort. Even in health children should not be allowed to use each other's towels or handkerchiefs.

Injuries to children's eyes should never be neglected. They are very difficult to examine as the child does not want to allow the eye to be touched. A skilled nurse however can usually get the eye open and see whether the injury is serious or not. If it is, it should be dealt with at an eye hospital since the possible complications of neglected injuries are severe. Children should not be allowed to rub their eyes, nor should they have their eyes washed out with any lotion or treated with ointment except on the advice of a doctor.

Lastly, attention should be paid to posture when reading, to the amount and direction of the light and to ensuring good food and sufficient sleep.

**2. Care of the eyes of adults:** Adults are engaged in various occupations, some of them involving great attention to detail and prolonged close work, others requiring good sight in the distance and accurate judgment of the position of things. If either the focus of the eyes or their power of movement and of working together is faulty, then symptoms of eye strain, fatigue and headache may appear and the quality of the work may fall off. Different errors of refraction are of importance in different kinds of work, and if there is discomfort a thorough eye test should be sought. Persons under the National Health Insurance are often entitled to free

consultation with an ophthalmic surgeon (arranged through their approved societies) and to the whole, or part, of the cost of spectacles. If they are not insured, advice can be obtained at any eye hospital, or privately by recommendation to a specialist through the patient's family doctor. Much time is often wasted through ignorance of what to do and through futile attempts to relieve the symptoms by means of eye lotions. If the eyes are healthy, not inflamed, and the glasses correct there is no need of eye lotions and, indeed, they may do harm if used indiscriminately. Their chief value is as antiseptics; their use can never influence sight.

Many forms of work carry special eye risks. For example, people working with carborundum and other grindstones or on lathes, are subjected to the risk of minute foreign bodies entering the eye. These may be trivial but sooner or later an accident may happen and an eye be lost. The management of the factory is under obligation to provide the right protective goggles and other safety devices for such workers, and it is the duty of every worker to make use of them and to insist that their maintenance is adequate. It is infinitely easier to prevent accidents to the eyes than it is to cure them once they have occurred. Every eye injury in a factory should be dealt with by the work's doctor or the First Aid nurse, and if serious sent on to an eye hospital at once. Do not attempt to remove embedded foreign bodies without adequate and absolutely clean instruments.

In some industrial processes there are special risks, such as that known as "welder's flash," or "arc eye," which is a burn from the ultra-violet light in the welder's arc, and the various types of irritation from fumes to which the workers in chemical industries are exposed. Most workshops keep the appropriate eye drops for the condition and they can be used by the patient or the First Aid organisation. If a burn or chemical injury does not clear up in a few hours further advice should be sought.

It must also be remembered that adults may suffer from certain eye diseases, quite apart from injuries at their work and from errors of refraction. These diseases may be local (*i.e.*, of the eye itself only) or general (*i.e.*, of the rest of the body, affecting the eye secondarily). Any case of persistent blurring of vision or pain or redness of an eye should be seen by a doctor. A chemist or an optician is not the proper person to deal with a diseased eye, though the public often seem confused about this, and do not differentiate between diseases and such conditions as long or short sight, which are malformations and therefore not serious in the same way as diseases. These latter, if not treated, may progress to blindness. Remember that a physician, by looking into a person's eyes with an instrument (an ophthalmoscope) can often see changes which lead him to diagnose diabetes or kidney disease or disease of the brain, among other things. Any defect of sight not corrected by glasses may be an indication of a bodily illness which requires treatment.

Some serious eye diseases (such as, for example, glaucoma) may be almost symptomless at the beginning, and therefore a periodic examination of the eyes of adults is desirable to detect early signs of disease. There is little risk of anything serious developing unnoticed between the ages of 21 and 40 but after 40 and certainly after 45, not only does the refraction and focusing power of the eye change appreciably in most people, but also diseases become more common. Eye examinations should be done every three or four years after the age of 40 in most people.

**3. The eyes in old age :** Some old people keep remarkably good sight till the end of their lives, but certain diseases such as cataract become common after 65 or so. Cataract is a slow opacification of the lens of the eye, and shows itself first as a great sense of dazzle if strong light falls directly on the eye. Reading does no harm in early cataract and much can be done to improve the sight by spectacles, and by arranging a reading lamp with an opaque shade so that the light is thrown on the book and not on the reader's face. In many people the cataract does not progress to blindness and no treatment is necessary. A number of quack treatments for cataract exist, which claim to arrest the progress of the disease, but with the onset of symptoms a doctor's advice should be sought.

Another cause of failing sight in old men is excessive pipe-smoking. If shag is smoked in a pipe regularly for 20-30 years there is risk that the absorbed tobacco will poison the optic nerve and the person will become nearly blind. Fortunately, if the smoking is stopped the sight usually returns. Conditions of debility and malnutrition (lack of certain vitamins) may also affect the sight. This may happen at any age.

We can, therefore, say that throughout life there are certain cardinal rules concerning eyes. These are :

1. Maintain a good posture and adequate lighting for all close work.
2. A full and varied diet.
3. Adequate fresh air and exercise.
4. Sufficient sleep.
5. Prompt attention to all eye defects, and periodic examination of the eyes.
6. Leave the eyes themselves alone. Do not handle them, massage or bathe them when they are healthy, and never use a towel or handkerchief which has been used by someone else.

# Compensation for Industrial Injury

PROFESSOR HERMANN LEVY.

UNDER the Workmen's Compensation Acts as we have known them since their inception in 1897, indemnification for industrial injury has not been a social service. Compensation of workers for injury, caused by accident or disease, has been made merely a liability, imposed by law upon employers. Industrial accident insurance was not compulsory nor was it administered by a special social insurance department of the State. Only in coal mining is there legislation, making insurance against claims for compensation compulsory (though to a limited extent) and the same applies to certain schemes related to a number of industrial diseases. At one time it was estimated that not less than 250,000 employers in Britain (mostly small manufacturers) remained uninsured, which means that the claimant for compensation might not get it all. Under the scheme now proposed by the Government (Social



Insurance, Part II—Workmen's Compensation) the liability, instead of being on the individual employer, will be placed on a Central Fund out of which all benefits will be paid.

Under this scheme then, industrial accident insurance would become a genuine social service, administered for the benefit of disabled workers, by a social insurance department which has been set up as a special Ministry. It remains an interesting fact that this proposed form of workmen's compensation has been taken out of the general social insurance scheme and made a separate branch of it. One might argue that sickness and illness are no less a misfortune in the workers' life than injury received by an industrial accident. They both deserve the most complete medical treatment. This will be provided under the new plans for a comprehensive medical service for the nation. In that respect the worker impaired by injury will not have any privilege over the worker whose sickness or injury is due to non-professional causes. The same principle would apply probably, to cash compensation if it could be paid at the liberal rate of providing workers during illness with their full wages. But as this cannot be envisaged even by the most social-minded scheme, it seems justifiable to pay a more liberal rate of cash benefits to the injured worker because, as the Government White Paper puts it, industrial injury has to be regarded as "one of the most grievous forms of personal misfortune."

Under the present system the discrepancy between cash payments under National Health Insurance and under Workmen's Compensation has been glaring. The discrepancy will be less under the new schemes. There is even a rather surprising special advantage provided as regards industrial injury allowance and industrial pension (if disablement is assessed at 100 per cent.) for single men, when their benefits are compared with those for sick or unemployed workers—a discrepancy or anomaly which has aroused some criticism among social reformers (*see* PEP, broadsheet of 23rd March, 1945, page seven). More important it is, to point out that with sickness insurance as well as with industrial accident insurance under the new schemes, the actual significance of the compensation payment to the disabled workers' budget will be very different when different levels of weekly earnings are affected. Most countries have made cash payments, under industrial accident insurance, a percentage of the pre-accident earnings of the worker. In some countries the percentage went as high as 80 per cent. In Britain it was, before the war, 50 per cent. with an over-riding maximum of 30s. which was increased to 35/55s. during the war, according to the period of illness and the number of dependants. Under the proposed schemes the percentage-of-earnings compensation is replaced by fixed rates. These again, distinguish between injury allowance payable during incapacity for work for the first 13 weeks; injury allowance after 13 weeks and pension for 100 per cent. disablement; and a pension, if 100 per cent. disabled and unemployable. The lowest payment will be made to a single man under the first group, with 35s.; the highest will be the pension under the third group for a married man and first child, with 67s. 6d. It is obvious that if the single worker, disabled for 13 weeks, was earning 50s. a week the compensation would be ample, even according to the internationally accepted standard of 66½ per cent. of his previous earnings. The sum of 67s. 6d. however, would not reach even this level where the impaired married worker with one child, had earned £6, or where he had earned £5 and would get, under the first

group of compensation payments 48s. 9d., under the second group 57s. 6d. The flat rate payment of cash compensation may have a good many administrative advantages, as it does away with the rather burdensome task of calculation of previous earnings which has given rise to many complications under the present Acts. But it entails certainly some injustice to impaired workers of the higher income groups.

There is however, a great and outstanding improvement set forth by the new schemes as regards cash benefits and this will be welcomed by the medical profession in particular. Doctors and surgeons have urged that lump sum payments should be abolished. The argument that the final settlement of a claim, by a lump sum payment, will remove the constant worry of impaired workers about their claims, and instil them with a fresh desire to use their partial disability at fullest advantage, has not proved valid because the long drawn out struggle for lump sum settlements under the present system, has led to a definite deterioration of the impaired workers' health and state of nerves. Very few countries have adopted the system of lump sum payments, but under the present Workmen's Compensation Acts in Britain, insurance offices, wishing to clear their accounts from disability cases as soon as possible, have used such settlements as a means of avoiding permanent weekly payments. The bargaining about the sum to be paid leads to protracted proceedings between the legal advisers of the offices and the impaired worker, much to the disadvantage of the latter. Under the new scheme there will be no commutation of a compensation payment or pension by a lump sum payment, except in some cases of minor disability. The present system of Workmen's Compensation has led to another evil in cases where the injured and partially disabled worker does not accept a lump sum, but prefers to stick to weekly payments. In such cases, *i.e.*, under the provisions of the Light Work clauses of the Acts, the employer may reduce the amount of the weekly payment to the workman if he can show that the workman is fit to undertake light work and if light work is available. In the majority of trades in which accidents occur there is no real light work, and jobs are made by the employer for the workman at the instigation of the insurers. In the building trade, for instance, a skilled artisan has to become a tea-boy or a sweeper-up, and an inferiority complex, perhaps not present before, is born immediately and with it a sense of bitter resentment against his employers and his fate. The White Paper on Workmen's Compensation re-affirmed this experience: "In many cases the workman has felt that the work offered to him was not suitable for his capacity or would be otherwise prejudicial to his complete recovery; or he has felt aggrieved because, though his compensation has been reduced, no work of the kind for which he is fitted has, in fact, been available. Or again, he has been reluctant to resume his old employment or to undertake new employment, from fear that his compensation would be reduced and that, if he failed to make good owing to his disability, he would find it difficult, if not impossible, to get his compensation restored to its previous level. In such cases the psychological effect is to delay the recovery of the workman." In the same way the Tomlinson report on Rehabilitation deprecated the present "system under which the provision of light employment is treated, not as a part of the rehabilitation process, but merely as a factor in determining the quantum of compensation."

In view of such evidence the framers of the new scheme felt that cash

compensation, for partially but permanently impaired workers, should be dealt with on an entirely different basis. Mr. Morrison, the Home Secretary, in explaining the new scheme to the House of Commons, did not hesitate to call this part of the scheme a "big and fundamental change" essential to the whole proposals of the White Paper (H.C. Debates, 8th November, 1944, col. 1397). Describing the uncertainties of the present system he said: "I do not want the workman's position to be that, if he should have to claim from his employer or the employer's insurance company and if he should have to have an argument with them, I want him to have certain social rights conferred upon him because of his injury."

It is this outlook, apart from merely administrative considerations, that prompted the drafters of the new scheme to abandon the principle of awarding compensation in respect of earning capacity as measured by pre-accident wages and post-accident potentialities of earning. Under the proposed scheme cash benefit will be given according to the degree of disablement, and the pensions to be given for permanent incapacity will be based upon the extent to which the workman has suffered disablement by comparison "with a normal healthy person of the same age and sex." The procedure will be the same as it is already under the war pensions schemes, namely through an assessment by a Medical Board of the condition resulting from the injury. The scheme recognises a certain similarity between the position of the soldier wounded in battle and that of the man injured in the course of his productive work for the community. Neither is liable to have his pension reduced on account of what he may earn after the injury; each is compensated, not for loss of earning capacity, but for whatever he lost in health, strength and the power to enjoy life. The latter phrase becomes of particular importance as regards people disfigured by industrial injury. Under the present law compensation for disfigurement becomes due only when the worker can prove that—through it—he has actually lost in earning capacity. Under the proposed scheme, regard is had to the fact that disfigurement may greatly impair the non-professional life of the injured, and it is suggested to assess this effect in the same manner as the purely professional handicap created by the accident or industrial disease.

The partially disabled worker with a permanent handicap will now have the certainty of a permanent unalterable payment for his physical impairment. The pension he gets will not be affected by any of his subsequent earnings. If he happens to recover some of his lost physical capacity after the fixing of the pension, he might derive an advantage from this by earning more. Quite contrary to the conditions which, as we have seen before, have developed under the present system of compensation payments and light work, the proposed system of compensation for physical loss would avoid any ground of suspicion on the part of the injured worker, that he is pressed to return to unsuitable work with a view to reducing his compensation, and the fear will be removed that, if he returns to work, he will jeopardise his right for further compensation. The worker will now be anxious to do everything possible to speed his recovery in order to be able to add more and more income to his pension.

The system of evaluating compensation payments through an assessment of physical incapacity, is not a new one in the international sphere of social insurance. It has been widely adopted in other countries. Doctors have argued that physical invalidity is meaningless and should be dismissed as

mere "medical methaphysics." It is functional, and not anatomical, evaluation of incapacity which is needed; not physical, but occupational incapacity has to be taken into account. The latter may be evaluated as incapacity for employment in a given undertaking or a group of undertakings; it may be incapacity for employment in a particular industry; it may be the loss or reduction of capacity for a particular occupation or group of occupations. It is in view of such distinctions that the General Council of the Trades Union Congress, while assuring the Government of a warm welcome for the new basis for workmen's compensation, has suggested that, in the assessment of the degrees of disablement, the comparison should not be only with the condition of a normal healthy person of the same age and sex, but also that account should be taken of the effect of the injury on the worker's ability to follow his own occupation. It is a suggestion which can hardly be ignored. But its realisation pre-supposes a far wider administrative machinery than the proposed social insurance schemes are at present envisaging. Among others it would require a close study of what Americans aptly call "job analysis," a study of the jobs as they fit the worker and of the worker as he may or may not be suitable for certain jobs. It is greatly to be hoped that such fine and differentiated criteria will, in the future, improve what now seems a rather rough method of evaluating incapacity and determining the fair amount of a pension for disabled workers. But the difficulties facing—for the present—the realisation of these well justified aims, should not detract our attention from the fact that the proposed scheme for the payment of pensions to injured workers, is undoubtedly a first step forward when compared with existing legislation.

#### POSTSCRIPT

The new National Insurance (Industrial Injury) Bill, published on 12th June, 1945 provides increases of compensation payments (over the White Paper proposals) for certain categories of the injured workers—the minimum being raised to 40s. for the temporarily injured. The wife of the injured worker and the married man with one child will also get more. Still, except for actual cripples, who will get the unemployment supplement increased by 10s. (to 20s.), even these more liberal rates will, in the case of the higher paid workers, not always reach the internationally accepted standard of 66½ per cent. of the pre-accident earnings, or the basic rate of 80 per cent. paid in Switzerland.

## Medical and Nursing Services in Factories

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IT has been known for centuries that occupations and conditions of work affect the health of the workers, but the practice of appointing doctors and nurses to look after them in their working environment, as distinct from their home environment, is of comparatively recent origin. Nevertheless it is recorded (S. A. Henry, 1944) that the East India Company in the 17th century appointed surgeons to its factories in India. In this chapter I propose to deal mainly with medical and nursing supervision in factories, but it must be remembered that the term "industry" has a wider application

than to those processes and premises covered by the Factories Act. For instance there are mines and quarries, transport undertakings of all kinds, agriculture and fisheries, all of which come under the definition of industry. Again the Post Office, which employs more workers than any other department of the Civil Service, has had a medical service since 1855, and because it deals with engineering and manual workers in addition to office staffs, might be called in part an industrial medical service. Other Government departments, such as the Ministry of Fuel and Power, the Ministry of Supply, and in a minor degree the Ministry of Health through the local authorities, play some part in controlling industrial medical services. But of all the departments supervising industrial health the main one is the Factory Department of the Home Office which was seconded in 1940 to the Ministry of Labour and National Service.

### **Factory Department.**

The Department had its origin in the appointment of four Inspectors of factories after the passing of the Factory Act of 1833. Since then the staff has increased steadily until it now numbers 401, of whom 14 are Medical Inspectors. All members of the Department, whether lay or medical, take part in the activities directed towards preventing illnesses and maintaining the health of the factory population. This fact is not generally known and needs emphasis. The District Inspectors and the members of their staffs, are constantly on the watch for processes and conditions likely to damage the health of the workers. When such conditions are found the Medical Inspectors are called in to investigate and advise on the health risk, in many cases after consultation with the specialist Engineering, Chemical and Electrical Inspectors. "A scheme of prevention is evolved and it is handed back to the District Inspector to administer, if covered by the ordinary law, or if not, the Minister is advised if new Regulations are thought to be necessary" (Sir Wilfrid Garrett, 1943). Recommendations are also made on diverse subjects not coming under law or regulation. The Medical Inspectors—who have to be highly qualified—are at present stationed in London, Birmingham, Sheffield, Liverpool, Glasgow and Wolverhampton, and from these centres are able to deal with factory health conditions in any part of the country.

It was not until 1896 when Sir Arthur Whitelegge was appointed Chief Inspector of Factories that a medical man came on to the staff of the Factory Department. Sir Arthur did not act in a medical capacity and two years later the first Medical Inspector of Factories was appointed. This was Dr. T. M. Legge (later Sir Thomas) who was responsible for much pioneer investigation of occupation health risks and for legislative measures for their prevention. At first Sir Thomas devoted himself to the study of the effects of the toxic substances used in industry, such as lead, arsenic and phosphorus. For example there are now in force 12 sets of regulations which govern the use of lead in various factory processes. Industrial lead poisoning became notifiable in 1896 and there were 1,058 cases notified in 1900 whereas in 1943 there were only 46. This is merely one example of the progress made. Another is the diminution of and lowered mortality from cases of anthrax. When other doctors were appointed to the Department the scope of the investigations became wider. E. L. Collis, J. C. Bridge, S. A. Henry,

E. L. Middleton, E. R. A. Merewether, Sibyl Horner and others became associated in investigations of such industrial conditions as pneumoconioses of varying types such as silicosis, asbestosis, occupational cancer, the toxicity of organic solvents, industrial dermatitis and others too numerous to mention here. In collaboration with the District Inspectors much attention has also been paid to the subject of welfare which is a term referring to those amenities which contribute in any way to the health and comfort of the worker. New technical processes and chemicals are constantly being introduced into industry and most of them bring new health risks which are dealt with by the staff.

### **Certifying (Examining) Surgeons.**

Under the Factory Act of 1844 power was given to the Inspectors of Factories to appoint a number of qualified doctors as "certifying" surgeons to examine the young factory workers and give them "surgical certificates" of age. These Certifying Surgeons were general practitioners and they were also required to report on accidents occurring in the factories. From this small beginning arose the present body of Examining Factory Surgeons (since the 1937 Factories Act they are called "Examining" and not "Certifying" Surgeons) who now number 1,725 and who perform useful and unobtrusive work, particularly in safeguarding the interests of young factory workers all over the country. They have duties both under the Factories Act and the Workmen's Compensation Acts. Under the former they are responsible for:

1. The clinical examination and issuing of certificates of fitness to young persons of 14-16 years of age employed in factories.
2. The periodical medical examination of workers employed in certain dangerous trades where such examinations are required under Regulations, *e.g.* lead processes, chromium plating, and the luminising of instrument dials with radio-active substances. They also carry out half-yearly examinations of males of 16-18 years of age who work at night in certain processes.
3. The investigation and reporting on cases of notifiable industrial diseases and on gassing accidents.

Under the Workmen's Compensation Acts they are required to examine and issue certificates to workpeople applying for compensation for industrial diseases scheduled under the Acts. In this connection they deal not only with factory workers but also with coal miners and domestic servants.

### **Mines and Quarries Medical Service.**

The medical service for mines and quarries is not as old as that for factories. Like the Factory Department medical service it is backed by an Act of Parliament. The Mines Department was transferred from the Home Office in 1920 to the Board of Trade and in 1943 to the new Ministry of Fuel and Power. The first medical man was appointed in 1923 to investigate the first aid arrangements in mines, and in 1927 the first and only Medical Inspector of Mines was appointed. When the Department was transferred to the Ministry of Fuel and Power he became Chief Medical Officer of a new medical branch which now consists, in addition to himself, of a Deputy Chief Medical Officer and eight Regional Mines Medical Officers. At the present time much of the work of the branch is concerned with applications for release from the mining industry on medical grounds. The Medical

Officers have charge of the first aid and ambulance arrangements at the mines and they study the working conditions and their effect on the miners' health. Much benefit to miners can be expected from this new service when it gets into its stride.

### **Silicosis and Asbestosis Medical Board**

The Silicosis and Asbestosis Medical Board co-operates with both the Factory Department and the Ministry of Fuel and Power. The Board was set up in 1931 under its first Chief Medical Officer, Dr. C. L. Sutherland. It consists of eleven permanent whole-time Medical Officers and some part-time doctors. In addition about ten whole-time temporary Medical Officers are employed in the South Wales area. The Board is divided into panels each of which is made of two doctors stationed at Sheffield, Cardiff, Swansea, Stoke-on-Trent, and Manchester. The Chief Medical Officer has his head office in Sheffield. The members of the Board have special experience of chest diseases and issue compensation certificates under special schemes relating to different pneumoconiosis-producing industries, to workers who develop silicosis, asbestosis, or miners' pneumoconiosis. They also carry out pre-employment and periodical medical examinations of workers in certain industries liable to cause silicosis and asbestosis. The temporary full-time Medical Officers are engaged mainly in the South Wales area to assist in dealing with the outstanding claims from miners for compensation for pneumoconiosis.

### **Byssinosis**

It has been established that cotton workers suffer from occupational pulmonary conditions called by the generic term of "byssinosis" and a special scheme for compensation has been evolved. A Medical Board consisting of three part-time doctors was set up in Manchester in 1941 to make diagnoses and to issue compensation certificates.

It might be added that all workmen's compensation schemes used to be administered by the Home Office but they now come under the new Ministry of National Insurance. No further reference will be made here to schemes for workmen's compensation because the whole subject is under review.

### **Industrial Health Research**

Apart from the investigations and research into industrial diseases conducted by the Medical Inspectors of Factories, the Mines Medical Officers, works Medical Officers and Examining Surgeons, much fundamental research into environmental conditions has been carried out by the investigators of the Industrial Health Research Board which developed from the Industrial Fatigue Research Board and this in turn came from the Health of Munition Workers Committee set up during the first World War in 1915. The Industrial Health Research Board is one of the departments of the Medical Research Council. The problems investigated include those of hours of work, lighting and vision, heating and ventilation, accident proneness and sickness absenteeism. These investigations were mainly physiological and statistical but clinical studies have also been carried out under the aegis of the Industrial Pulmonary Diseases Committee of the Medical Research Council, *e.g.* comprehensive inquiries into the pneumoconiosis of South

Wales coal miners and the byssinosis of cotton operatives. It became apparent that more clinical research into occupational diseases was needed and the Medical Research Council in 1942 appointed a Director of Research in Industrial Medicine. Finally, in 1943, a Department for Research in Industrial Medicine was established under the Council at the London Hospital. Since then much excellent research work into problems of industrial health has been done.

### **Works Medical Officers**

The practice of appointing whole-time or part-time Medical Officers to factories has developed slowly in this country. Sir Thomas Legge has pointed out that the National Health Insurance Act, 1911, which instituted the system of panel doctors, prevented the appointment of works Medical Officers because the employer, the worker and the State each pay a contribution to cover medical attention when the worker is ill. In the United States however where there is no panel system, many more whole-time and part-time Medical Officers have been appointed to individual factories. But it is recorded that in 1830 a works doctor was appointed to a worsted spinning factory in Yorkshire, his duty being to visit the factory daily and to watch the effect of the work on the health of the child workers. Another works doctor was appointed in 1845 by a Lancashire firm to attend the factory for one hour a day. During the first decade of this century several progressive firms, mainly food and chocolate factories, appointed whole-time works Medical Officers but it was the advent of the 1914-18 war which stimulated more widespread interest in the health of the workers and led to the appointment of works Medical Officers, particularly in the Ministry of Supply factories. After the war about 50 whole-time works Medical Officers were appointed to various large factories throughout the country. Dr. J. C. Bridge (1932) attributed most of these appointments to the realisation by the employers that the health of the worker was of great economic value—in other words, that the installation of a factory medical service was a paying proposition. "It seems to me," he wrote, "that during this period (the 1914-18 war) it was realised for the first time that conditions special to the occupation were not the only cause of industrial disease, but that other factors—fatigue, undernourishment and other conditions—were as important in the production of illness as those produced by the materials handled."

When war broke out again in 1939 the lessons of the previous war as regards factory medical services were applied and in 1940 the Minister of Labour and National Service issued the Factories (Medical and Welfare Services) Order. The Order stated in effect that the occupier of a factory in which any work for the Crown was being done might be required by the Chief Inspector of Factories on behalf of the Minister to appoint Medical Officers, nurses and welfare supervisors to look after the health and welfare of the workers. Mainly owing to the stimulus of the Minister's Order there has been a substantial increase in the number of whole-time and part-time factory Medical Officers and also of the number of nurses. In 1943 there were 926 works Medical Officers, of whom 63 were women. Whole-time doctors numbered 176 and part-time 750. The figures would have been much higher had there not been a great shortage of doctors owing to the call-up for the Forces.



During this war the Ministry of Supply has built up a large factory medical service under a Chief Medical Officer. Both whole-time and part-time doctors have been appointed to the various factories throughout the country. In many of them explosives are made or handled and a close watch has been kept on the effects of these poisonous chemicals.

In 1942 medical services for dock workers were set up in Manchester, Liverpool and Clydeside and similar services are being developed in London and South Wales.

The duties of a works Medical Officer are discussed in a Government pamphlet entitled "Medical Supervision in Factories" and are summarised briefly as follows:

1. To be responsible for the organisation and supervision of first aid services for the treatment of injury and sickness. The Medical Officer would not undertake any treatment at the home, and would only give continued treatment at the works, with the acquiescence of the patient's panel practitioner.

2. To examine medically and advise persons referred to him by, or through, the Labour Manager or individual employees who consult him, and to carry out the medical examination of persons about to be employed in processes involving a specific health hazard.

3. To take suitable means to assure himself of the fitness or otherwise of persons returning to work after illness.

4. To advise the management on matters of general hygiene within the factory.

5. To co-operate with the management and with outside welfare authorities on all matters affecting the health of the workpeople.

6. To create and maintain an effective liaison with outside health services, *e.g.* medical practitioners, hospital services and local authorities.

7. To keep, in confidential form, adequate and suitable records of his work.

8. To promote the education of the workpeople, collectively and individually, in matters of general and personal hygiene.

Canteen services and the nutrition of the workers are also the concern of works Medical Officers. During the war they assisted in the training of the A.R.P. staff. It has been emphasised that it is the duty of the works Medical Officer to know the workers individually, all the processes in the factory, and to spend a good deal of his time in observing the conditions of work. It is also suggested that from time to time he should get into working clothes and do the actual factory work. In this way he is able to get a better idea of the workers' reaction to their environment and the value of his medical advice will thereby be enhanced. Inevitably the works Medical Officers now have an important rôle to play in the schemes for the reconditioning and resettlement of disabled persons in industry. With their first-hand knowledge of the processes carried out in the factories and of the physical and mental capacities of the workers they will be able to place disabled persons in suitable jobs and keep them under observation.

### **Industrial Nurses.**

The development of medical services in industry has been followed naturally by nursing services. It is a truism that a doctor does better work when helped by an efficient nurse and conversely that the nurse works best

under the supervision of a doctor. But the industrial medical and nursing services follow no regular pattern and are by no means complete. Some factories have both doctors and nurses, others have nurses and no doctors, and still again many factories have neither doctors nor nurses. In the last group the management are content to rely on the services of first aid workers who, within their limits, have done and are doing excellent work. Even when both doctors and nurses are employed there is still an important part in the health organisation for the first aid worker who, if well trained, can be regarded as indispensable, especially in the heavy industries. For instance if there is a serious works accident the first aid team can go on to crane tracks, into soaking pits, to the top of blast furnaces, and generally into places where it would be unsuitable for women nurses to go. Indeed there is a place for male nurses in heavy industry and some 200 are now employed.

The first industrial nurse in this country was employed by a Norwich firm in 1878. She appears to have combined her factory work with District nursing in that she visited the sick workers at their homes. When, in the first years of this century, several firms appointed whole-time doctors in their factories, nurses were also appointed. One large firm about 1918 came to the conclusion whether rightly or not, that a nursing service would be of more value to the workers than a medical service, and an elaborate organisation consisting of 18 trained nurses was formed. Some of the nurses were engaged to visit the workers at their homes and to follow up cases of illness and injury. In many ways the experiment was successful but later doctors were retained by the firm to give advice on difficult cases when asked to do so by the nurses. Finally it was decided to appoint a whole-time Medical Officer.

In 1935 the Royal College of Nursing in association with the Bedford College for women devised a scheme of training for industrial nurses. The course lasted for a year and the successful candidates were given a Certificate "A" at the end of it. It has thus been recognised that the scope and duties of industrial nursing differ in many respects from other forms of nursing such as that required in hospitals both general and special, or in district work and health visiting. A Certificate "B" was given at the end of a six months course. At the outbreak of war in 1939, bringing with it an increased demand for nurses in industry, the course was shortened to three months. The Ministry of Labour and National Service also subsidised a course of instruction lasting for six weeks. Correspondence courses were instituted for nurses who could not leave their factories.

The duties of an industrial nurse vary from factory to factory. Her responsibilities will naturally be greater if there is no works Medical Officer. In some of the smaller factories she is also called on to do welfare work. Generally however she looks after the works surgery and its equipment, attends to workers who are injured or ill, and refers those who need medical attention to their doctors or to the works Medical Officer if there is one. She is not qualified to make diagnosis except tentative ones but she has to have some clinical instinct and knowledge to know whether a worker should be seen by a doctor or not, and in cases of doubt she is advised never to take the responsibility of not getting a medical opinion. She also has charge of the women's rest rooms and is specially qualified to take care of women workers suffering from minor disorders of menstruation. Another part of her duties is to arrange and assist in the clinical examinations of the workers

by the works Medical Officer or by the Examining Surgeon. Records of the attendances by the workers at the surgery are also kept. She is required to know something of the health sections of the Factories Act and the Regulations for dangerous trades and the Welfare Orders applying to her particular factory. In short her duties may be said to consist of every activity which will help to conserve the workers' health and efficiency.

The number of nurses engaged in industry varies from day to day, owing mainly to the fact that nurses are now subject to direction by the Ministry of Labour and National Service. Industrial nursing is low on the list of priority and some factory nurses are being directed to other civilian nursing services or to the military forces. In spite of the shortage of nurses it is hoped to keep the industrial nursing services at a reasonable strength because they are of great value in helping to maintain the health of the factory population. According to a recent return 7,600 nurses are employed in factories, and about half of them are State registered. Only about 200 men are employed as nurses and 22 of these hold the S.R.N. qualification.

Both medical and nursing services in industry have proved their worth during the war. Their future is uncertain but in common with other branches of both professions changes in the organisation and administration are bound to take place when the National Health Service is introduced. There seems to be little doubt however that the industrial medical and nursing services are to be maintained and strengthened.

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## Emergency Medical Service

Dr. L. HADEN GUEST, M.P.

IN 1938 a survey of hospitals in the United Kingdom was made under Government authority as part of the nation's preparation for war. It was a survey of all kinds of hospitals—the great teaching hospitals of London, Edinburgh, Belfast, Manchester, Liverpool and other cities; of the voluntary hospitals of little towns and country areas; of the great service of county hospitals under the control of the local government authorities of London, Lancashire, Yorkshire and all the other county authorities; and of the great service of institutions outside of all these—those hospitals and institutions used for the care and treatment of the insane and the feeble-minded, many of which are very large and are housed in very good buildings and surrounded by extensive grounds and lands of their own. These

institutions are so large that it was considered that a part of their accommodation could be made available for casualties, and this was done up to the end of the war.

All of these hospitals, and others not mentioned but excluding the special hospitals required for the treatment of infectious disease, were surveyed with the object of providing a completely linked up and integrated system of hospitals for the country as a whole. This was to be the Emergency Hospitals Service with which the country would meet the impact of war.

The Emergency Medical Service organisation was based on knowledge that the nation must prepare for extensive air raids. In warfare of this kind it was clearly impracticable to divide, in any rigid way, the treatment of service and civilian casualties. From the beginning, the E.M.S. set out to provide treatment for all casualties, service or civilian.

In the early conception of the E.M.S., the organisation was dominated by the need to provide hospital accommodation and treatment for casualties which were the result of extensive air raid attack. It was calculated before the war began that we should need to provide for 300,000 casualties at any moment after the outbreak of hostilities. This we set out to do but we had not only to provide hospital beds but to re-arrange and reorganise hospitals.

It will be remembered that part of the Government's arrangements for meeting the menace of air attack was a big scheme of evacuation from London and other likely targets, to areas less likely to attract bombing. An idea parallel to this was applied to the distribution of hospital accommodation. Hospitals were divided into casualty receiving hospitals in the dangerous areas and base hospitals in the suburban and rural areas. The principle of distribution of risk was applied to the hospital service in the following way. Bed accommodation, members of medical and nursing staff, medical and surgical equipment of all kinds (including operating theatres) were reduced in the casualty receiving hospitals and increased in the base hospitals. In London twelve of the big teaching hospitals were chosen as the heads of a sector organisation which divided London into twelve cones, each starting at a central hospital and which stretched out from London into the area around for many miles. Thus from the London Hospital, the head of one sector, two diverging lines drawn on the map stretched out to Southend in the Thames Estuary and Colchester in Essex. From the south of London the sectors stretched out as far as Basingstoke, in the west as far as Staines and Slough and in the north as far as Bedford. Inside each of these sectors all the hospitals placed under the control of the E.M.S. (and that was nearly all of them) were linked together and controlled as one unit. Sectors were also linked with each other. The head hospital of each sector distributed its medical and surgical staff with a view to convenience of work and safety of patients. During the war period a large part of the work of all the main teaching hospitals of London was carried out not in the familiar Guys, Barts, St. George's or St. Thomas's but in buildings many miles away from London in purely rural surroundings.

Organisation on the same pattern was applied in the other big hospital areas of the country, such as that around Birmingham and that around Manchester, but the pattern of radial sector organisation was only used in London. During the course of the war there were occasions when mass movements of hospital patients took place. At one time, when it was expected that the east, south and south-east coasts might be subjected to heavy attack,

a large part of the patients hospitalised in or near these areas were removed by ambulance, train, and motor ambulance convoys, and distributed to other hospitals in the Midlands and west of England. In another period hospital accommodation in many places near the coast had to be reduced by closing the upper storeys of hospitals as a precaution against bombing. This was also done in the London area at a certain period.

From the beginning of the war it was arranged that the E.M.S. hospitals would admit for treatment any Service cases needing it which could not conveniently be treated in the few purely Service hospitals provided. But up to the time of Dunkirk a very large proportion of war casualties and sickness in the army was hospitalised in France, at the big hospital base at Dieppe and elsewhere. The Navy, with its relatively limited numbers, had always expected to make its own arrangements for treatment of sick and wounded. The Air Force was to a large extent in the same position as the Navy. The retreat of the British army from France in 1940 meant the loss of the whole hospital base in France, the loss of the great stores of medical and other hospital equipment and the loss of many field ambulances and casualty clearing stations.

In this critical situation the existence of the Emergency Medical Service in the United Kingdom was of the greatest possible help. Provision for the use of E.M.S. hospital accommodation by service personnel had been arranged as part of the general plan prior to the Dunkirk disaster, and it went a very long way to save the situation from the medical point of view.

As the Army was built up again after Dunkirk it was provided with medical officers for battalions and other units, with field ambulances as part of the organisation of divisions, and with some casualty clearing stations and general hospitals designed for foreign service. But the Army, while still in this country, relied for a very large part of its hospital treatment on the E.M.S. During the period from the month of July 1940 to the autumn of 1941 the E.M.S. developed and expanded its work for the Army, and created special services in special hospitals. Owing to the continually increasing use of E.M.S. hospitals by the Army it was found necessary to provide them with a skeleton military organisation for purely army purposes. This was done by forming the E.M.S. hospitals into large groups, corresponding with the military commands into which the country was divided, and appointing to each of these groups a number of military registers to carry out all the necessary duties in connection with such administrative matters as pay, transport and discharge of army patients. The value of this organisation which led to a great economy in the use of service doctors and R.A.M.C. personnel was very great.

But the E.M.S. organisation on its military side became of first rate strategical importance when plans were being made for D-day in 1944, because it relieved army organisation (medical and administrative and especially supply and movement) of a gigantic load which it would otherwise have had to bear. On D-day and after, the existence of the E.M.S. was a factor of prime importance. It became the home hospital base of the advancing armies and left the invading forces free for rapid movement and swift action in the field.

Medical planning for D-day included detailed planning of the part which would be played by the E.M.S. Arrangements were made to bring back casualties from Normandy to England in hospital ships, hospital carriers

and, in the beginning, in any kind of craft. Very many casualties were brought to Southampton. Here arrangements had been made with a number of hospitals to take in cases which needed treatment or rest before proceeding further on their journeys. These "port" hospitals worked as part of the E.M.S. service although one of them was the famous naval hospital of Haslar. Casualties who were fit to proceed further afield were transferred from the carrier or hospital ship into an ambulance train which took its charges to a hospital ready to receive them. Soon after D-day other casualties were evacuated in Dakota planes straight from air strips in Normandy to an aerodrome near Swindon where again similar "port" hospitals were provided near the airfield for casualties needing admission, and ambulance trains were ready for those who could go further afield. It is noteworthy that for the whole of the time this organisation of evacuation of casualties by sea and by air was working from D-day onwards, there was never any systematic attack by air and attacks by sea were not serious.

The evacuation of casualties from Normandy and from other parts of the Continent later on, was controlled on the army side by two special evacuation organisations, one at Southampton controlling that by sea and one near Swindon, controlling that by air. These organisations worked in complete accord with the Ministry of Health representatives of the E.M.S. and with the E.M.S. hospital organisation. This co-operation had all been worked out as part of the main planning of D-day operation and it worked without any friction or any hold up.

### **Regional Organisation of the E.M.S.**

Before war began it was expected that air attacks would be very intense. As a means of protection against the possible breakdown of the organisation of government as a result of this intensive bombing of railways, roads and all means of communication, Great Britain for war purposes was divided into twelve Civil Defence Regions. One of the regions included all Scotland, another region was practically the same as the London Postal District, that is, greater London. A large part of the Eastern counties, with headquarters at Cambridge, made up another region.

If any region had been isolated by bombing from other parts of the country its Chief Regional Officer, the Civil Commissioner, with his staff representing the Medical and Health services, the Transport services, the Food services, the Government services and all the Civil Defence services, would have been able to carry on independently. This organisation, which was never called into action in its complete form, proved to be of great convenience to the E.M.S., as it was to Civil Defence, Food services and other services. This regional organisation proved to be a convenient way of dividing up all forms of civil administration.

The whole E.M.S. service of the United Kingdom was controlled by the Minister of Health, and for Scotland by the Secretary of State. The officers of the Ministry controlling the E.M.S. from London were as continuously on duty as were the medical services of the Army, Navy and Air Force. A number of them invariably slept at the Ministry of Health and there was always someone on duty there day and night.

Such matters as the Ministry of Health part in the reception of convoys of wounded from overseas by sea and air, the selection of hospitals in different

parts of the country to which these convoys were to be directed, the direction of the movements of the ambulance trains and motor ambulance convoys, were controlled from the Ministry direct, in co-operation with the different armed services. But the administration was much simplified for many matters by the Regional organisation in which direction came from the headquarters of each region, again in co-operation with representatives of the service departments.

### **Classification of Hospitals**

The principal casualty hospitals were classified in Class 1A. In this class were included the larger hospitals which already had, or could be provided with, full facilities for dealing with all classes of surgical and medical cases.

Small hospitals and certain special hospitals were classified as 1B. There were also hospitals grouped as Class 2, which were to be used for convalescent cases, chronic cases and in-patients not requiring special treatment.

By 31st March, 1941, 80 per cent. of the 3,000 voluntary and municipal hospitals in England and Wales were within the scheme. It was found by experience that the figure of 300,000 beds for air raid casualties was not required at any one time, but up to the time of the air raids in September 1940, from 140,000 to 150,000 beds were held ready. In addition to making use of the accommodation in existing hospitals the E.M.S. built many additional wards to the hospitals and erected new hutment hospitals. This added 40,000 beds. There was also built up during 1941 a network of convalescent hospitals, usually situated in large private homes taken over for the purpose, in which service personnel got the opportunity of good convalescent treatment.

### **Methods of Treatment**

The E.M.S. hospitals organisation provided not only for treatment of medical and surgical cases in general hospitals, but also for a great variety of treatment in special hospitals giving special treatment. The old idea of a "general" hospital has given way to an inter-related system of hospitals each of which has been staffed and equipped to deal with specific diseases or injuries. The following list is not complete but gives an idea of the range of treatment offered.

To deal with fractures there are 22 orthopaedic centres, supplemented by 85 fracture departments of other hospitals which deal with all but the very complicated cases, and there are over 300 fracture departments and clinics for cases only needing a short stay.

For peripheral nerve injuries there are 26 special centres (usually associated with orthopaedic centres); for neurosis nine special centres; for effort syndrome one special centre; for chest injuries 11 special centres; for spine injuries nine special centres; for head injuries ten special centres; for plastic surgery and face injuries 12 special centres; for burns three special centres; for skin diseases 20 special centres; for rheumatic cases three special centres; and for trachoma one special centre.

The developments of brain surgery, neuro-surgery, chest surgery, plastic surgery (especially in connection with injuries to face and neck) and orthopaedic surgery have been rapid and in some ways revolutionary during this war.

From the beginning of the war the group of drugs known as the sulpho

group has been of the greatest help in the control of septic infection. But most revolutionary of surgical changes during the earlier part of the war was the development of the use of blood transfusion on a great scale. The E.M.S. organised methods of collecting blood from large numbers of donors in different parts of the country and methods of storing that blood over long periods in "blood banks." The Army blood transfusion unit at Bristol did the same service for the Army and the two services, E.M.S. and Army Transfusion Services have undoubtedly been the means not only of saving many lives but of restoring wounded men much more rapidly to health than would otherwise have been possible. The blood transfusion service is under the direction of experts appointed by the chief medical research organisation in the country, the Medical Research Council.

From D-day onwards Penicillin was available for the treatment of wounds both by the services and by the E.M.S. hospitals and has saved very many lives.

In speaking of the E.M.S. hospitals, information has been given of the number of hospitals available, the number of beds kept ready for casualties and the variety of special centres at which specialist treatment is given. The work has been done by a large number of general duty doctors and nurses, by specialist-surgeons and physicians, by highly qualified consultants and advisers. In the London region the doctors taking part in the work have been those associated with London's famous voluntary and teaching hospitals and with London's county hospitals led by the chief post graduate institution in London, the county hospital at Ducane Road, Hammersmith. In the Birmingham region, the work has been done with the help of the staffs—medical and surgical, specialist and consultant—of the great Birmingham Hospital centre (not yet completed) and the many excellent institutions in that great hospital area. Everywhere the best medical ability in the country still remaining in civil life during the war has been available for the E.M.S. It is true that many of the most famous names in medicine, surgery and in many specialities have joined up with the Army, the Navy and the Air Force to serve in one of these services in a military capacity. Either in the services or in the E.M.S. the best men that medical training and experience can offer have been at the service of the sick and wounded fighters in the war.

The chapter of rehabilitation of war casualties—it is of course equally applicable to the victims of accident or of disease in civil life—is likely to add fresh laurels to the great record to date of the E.M.S.

## Dental Health

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TOWARDS the end of the war of 1914-18, a powerful stimulus to interest in the cause and prevention of diseases of the teeth and jaws was given by the experimental studies of the Mellanbys on the bearing of nutrition upon these and other parts of the body. Space permits no detailed description of these fundamental researches, but their influence, on the trend of subsequent



dental investigations in all parts of the world, can be well illustrated by all brief consideration of the more important findings and of the scientific methods by which they were brought to light.

Previous views on dental caries (decay) and so-called pyorrhoea were based largely on clinical impressions and theoretical inferences from the reaction of test-tube cultures of bacteria recovered from saliva and diseased oral tissues. Such studies resulted in the eagerly accepted belief that all diseases of the teeth and gums, other than those associated with metallic poisoning, were of bacterial origin and were directly related to inefficient mouth hygiene. The measures prescribed for the prevention of these conditions were increased consumption of foods requiring vigorous chewing with a free flow of saliva and a simultaneously reduced intake of food articles needing little mastication. In other words, the *physical* rather than the chemical characteristics of the diet were considered relevant to the problem. Treatment of established tooth decay consisted in the removal of the diseased tissue and filling of the cavity with some convenient inert substitute; for pyorrhoea, removal of tartar by scaling and application of caustics of astringents to the affected gum. All of these procedures were augmented by cogent advice on the vital importance of regular brushing of the teeth and gums, with the aid of whatever dentifrice was then in vogue. Propaganda along these lines was widely disseminated, as instanced by posters and other exhibits in hospitals and clinics.

Before the last world war then, the "hygienic" conception of dental pathology was unchallenged. Both caries (decay) and so-called pyorrhoea were associated with dirtiness of the mouth and factors relating to the general health of the organism were dismissed as of little or no account. Caries was stated to be the result of dissolution of the tooth enamel by the acid products of fermenting carbohydrate food debris retained about the teeth. Pyorrhoea and other forms of gum disease were claimed to be due to putrefaction of mainly protein elements of the food, resulting in breakdown of the gum surface and the formation of pockets along the tooth roots thus allowing subsequent infection and destruction of the surrounding jaw bone. From 1918 onwards however, came reports of controlled laboratory investigations on the influence of certain *chemical* properties of the diet on the development and structure of the dental tissues and their susceptibility to disease, and a new era of dental research was born. For the first time the scientific experimental method was applied on a large scale to problems of dental health, and elaborate theoretical essays based on empirical impressions were replaced by verifiable facts. This new method of approach in itself led to an enormous increase in the number of studies designed to shed light on various aspects of dental pathology. It is possible to mention only a few of the more important sequelae to this changed conception of dental science, but in general, the most outstanding involved the realisation that the resistance of the oral tissues to disease was closely related to those nutritional factors which play so significant a part in maintaining the health of the body as a whole.

### **Dental Caries (Decay)**

Experimental and clinical investigations have demonstrated a fairly high degree of association between the susceptibility of a tooth to decay and the structure (*i.e.* minute architecture) of the tissues comprising it, both of which

are in turn related to the calcifying properties of the diet. Studies on the human subject in this country <sup>1</sup> Canada, America, Scandinavia and elsewhere, have shown clearly that nutritional factors such as vitamin D, and to a lesser extent salts of calcium and phosphorus, are of real significance in maintaining or restoring dental health. On the other hand, no claim is made that the consumption of foodstuffs (milk, butter, cheese, eggs, fish-liver oils, etc.) rich in these compounds play more than a part, though an important one, in the promotion of resistance to decay. Other factors will undoubtedly be found and recent investigations have suggested that the fluorine content of the drinking water may be one of them <sup>2</sup>. But although for example, in parts of Essex (Maldon) the water is relatively rich in this element and the general level of caries incidence is lower than in many parts of Britain, it has been shown that a high fluorine intake is not necessarily incompatible with rampant decay <sup>3</sup>.

### **Diseases of the Gums and Supporting Structures of the Teeth**

Vitamin A and its precursor carotene, the vitamin B<sub>2</sub> complex and vitamin C, would all appear to have some influence on the resistance of the gums and adjacent tissues to disease. In the laboratory, deficiency of vitamin A leads to inflammatory and other changes in the gums, the end-results of which are not unlike the condition popularly known as pyorrhoea in man. Experimental deprivation of some compounds of the vitamin B<sub>2</sub> complex, notably nicotinic acid, lead to haemorrhagic ulceration of the gums, cheeks, lips, tonsils and tongue, with swelling and tenderness of the neighbouring glands <sup>4</sup>. Deficiency of another B<sub>2</sub> vitamin is accompanied by eye lesions, by dryness and cracking of the corners of the mouth and outer aspects of the lips, and by soreness of the tongue. Both these latter syndromes have their counterpart in man. Deficient intake of vitamin C (ascorbic acid) leads to scurvy, one of the later signs of which is swelling and bleeding of the gums in animal and human subjects. On the other hand, forms of gum disease associated with the deposition of tartar on the teeth may very well be caused or accentuated by lack of roughage in the diet, even when the latter is of adequate nutritional value <sup>5</sup>.

### **Practical Application of Current Knowledge**

At the present time we still lack precise information concerning the initial breakdown of the teeth or gums, and for this reason an authoritative pronouncement of the best way of dealing with the grave problem of dental disease is impossible. We have however, certain means by which the ravages of these lesions may be significantly reduced.

Comparison of the dental conditions in five-year-old London children in 1929 and 1943 <sup>6</sup> has shown a marked decrease in both the incidence and extent of caries. During this period local authorities, and later the central government, have made increasing efforts to improve the nutrition of expectant and lactating mothers and their offspring. Amongst the measures introduced were larger supplies of milk (free or at a much reduced price) and, rather more recently, of cod liver oil, halibut liver oil, and other vitamin D-containing preparations. Thus, the increased resistance of the teeth to

decay found in the London children in 1943 was coincidental with the progressive application, in part at least, of the very suggestions made by the Mellanbys some years ago, *viz.*, that improved dental health could be effected by (a) increasing consumption of milk, eggs, cheese, green vegetables and other foods rich in vitamin D, calcium and phosphorus; (b) decreasing intake of cereals such as white flour and oatmeal; (c) reinforcing the diet with cod liver oil or various vitamin D-containing preparations.

As regards lesions of the *gums*, the position is less satisfactory. Vitamins probably have their part in assisting the maintenance or recovery of gingival health. Nicotinic acid or the whole B complex in the form of special yeast preparations are of therapeutic value in some instances and ascorbic acid (vitamin C) has its supporters. In the case of the gum tissues, however, it is possible that the chemical and physical characteristics of the food each have their part in promoting or degrading oral health. Bearing this in mind, the family physician is well advised to prescribe green vegetables, raw salads (including carrots), fresh fruit, meat and offal, so as to include both roughage and protective foods for the expectant mother and for her child as soon as the latter is able to take them.

### **The Need for Further Research**

While there is now more cause for optimism than in past decades, the dental health of future generations is essentially dependent on further research by investigators properly trained in the medical and allied sciences. From the foregoing discussion, necessarily brief, and from current dental propaganda, it is obvious that the road to good dental health is long and beset with pitfalls of prejudice and ignorance. In spite of all that has been written, we are still, ignorant of the *cause* of the diseases with which the dental profession is called upon to deal. Local surgical treatment of established lesions of the teeth or gums, though essentially symptomatic and largely palliative, nevertheless must largely suffice for the present and probably for many years to come. As to prevention, it has not yet acquired the glamour or drama of cure, and the prophylactic measures so often prescribed frequently lack any scientific basis. For example, we are told that decay is due to the disintegration by the acid-containing fermentation products of debris from bread, biscuits, sweets, etc. Not a shred of real evidence has been adduced to support this contention or to suggest that measures based on such beliefs make any significant contribution to dental health. These and other theoretical statements must be tested and upheld, or scrapped.

During the past twenty-five years it has been the policy of the Medical Research Council to support researches into the cause and means of prevention of dental disease. The record of those investigations which the Council have already sponsored is formidable. It is not to be doubted that, with the increasing help of the universities and dental schools, the solution of the main problems will be found at no distant date. There is however, one pre-requisite for attaining this goal—the provision of a sufficient number of investigators fully trained in the methods of scientific research. Unless the universities and other authorities can guarantee this, future generations will still be denied their birthright of natural dentures, and will be able to retain their masticatory powers in adult life only with the aid of inefficient plastic or metal substitutes.

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# The Juvenile Court and Child Protection

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LORD Justice Lindley dealing, in 1893, with a case concerning the custody of children said: "The dominant matter for the consideration of the court is the welfare of the child. But the welfare of the child is not to be measured by money only, or by physical comfort only. The word "welfare" must be taken in its widest sense. The moral and religious welfare of the child must be considered as well as its physical well-being. Nor can the ties of affection be disregarded."

The Children and Young Persons Act of 1933, Section 44, lays down in words which echo Lord Lindley: "Every Court in dealing with a child or young person who is brought before it, either as being in need of care or protection, as an offender, or otherwise, shall have regard to the welfare of the child or young person, and shall in a proper case take steps for removing him from undesirable surroundings, and for securing that proper provision is made for his education and training."

In 50 years the law has been adjusted to a new conception of children's value and significance to society, and of the obligations which society has to children. So Part I of the Children and Young Persons Act is concerned with "Prevention of Cruelty and Exposure to Moral and Physical Danger"; Part II with "Employment"; Part III with "Protection of Children and Young Persons in relation to Criminal and Summary Proceedings"; Part IV with "Remand Homes, Approved Schools, and Persons to whose care Children and Young Persons may be committed"; Part V with "Homes supported by Voluntary Contributions." The emphasis in the case of delinquents, as well as victims of neglect or cruelty, is on protection and the proper care and training of the young. So the law and the Parliament which begat it mean well, even if the machinery they have designed is not altogether up to date, and is often inclined to creak and to work with too many bumps and jars, especially if the "machine minders" (judges, magistrates, clerks, education officers and committees, probation officers, Poor

Law officers, matrons and headmasters of homes and schools) are unskilled or careless. No law is or can be foolproof.

The Juvenile Court is concerned less with "Thou shalt not" than with "Thou shalt," and when it is working well, it is making a positive contribution to the welfare of the child and its family. The Court is composed of at least two, and at most three, magistrates, and only those chosen for three yearly periods by their Bench to be members of the Juvenile Court Panel may sit in that Court. One of the magistrates must be a man (except in London, where in certain circumstances two women may constitute the Court), and one if possible should be a woman. A mixed Bench has obvious advantages, but in some parts of the country there are not enough women magistrates to serve every session of the Juvenile Court. The Juvenile Court Panel is intended to be composed of magistrates with special interest in, and knowledge of, youth problems. There is no age limit, but Benches are exhorted by the Home Secretary to aim at providing children's magistrates of parental rather than grandparental age, and recently the Lord Chancellor has requested all justices over 75 to retire from the panels, and his wishes have been respected by all the justices concerned. Most people agree that more younger magistrates, *e.g.*, from 35-50, are needed, although it is recognised that good children's Court magistrates often retain sympathy with and understanding of youth, and that some of the younger justices are less imaginative and enterprising in their dealings with boys and girls than are many of the older ones. Age must not be the sole criterion, but age normally brings with it a remoteness from the teeming difficulties of adolescence and the small child's world of imagination and play. Worst of all, age brings deafness and whatever else a magistrate must do, he must *hear* the case.

The Juvenile Court meets in a room or building not used for ordinary criminal courts. It is not actually illegal for it to meet in the adult court room, provided that it is at a different time or on a different day; but this is contrary to the spirit of the law for the preservation of the young from the sordidness of the criminal machine, and no Bench which wants to do its duty will tolerate such an arrangement. Bona-fide representatives of the press may attend but, apart from this guarantee against trials in camera, the public is excluded, and the press may not publish the child's name, address, school, photograph or anything to reveal his identity. The Juvenile Court should try to combine dignity and order with informality and a friendly atmosphere, in which the small John or the defiant "just growing up" Mary, may be enabled to talk with some ease and freedom with the magistrates.

The age run for the Juvenile Court "clients" is from 0 to 17 years, for even the tiniest baby can be brought for adoption, or for the appointment of someone to give it care or protection, if its parents or guardians have failed it. So far as offenders are concerned, there is a lower age limit of eight, for on the eighth birthday the young John citizen becomes responsible in the eyes of the law for his conduct. Hence the tale that a little boy, who was the leading spirit of a gang of gas meter thieves, cocked a snook at the policeman and said: "You can't get me, I'm only seven." In fact, the small boy's law was not entirely sound, for while "criminal responsibility" starts at eight, any child who is running riot in this way may be brought before the Court by parent or guardian as being "beyond control," and there is no lower age limit.

Thus there are five tasks before the Juvenile Court :

1. To deal with children from 8 to 17 charged with offences ranging from such things as riding bicycles on the footpath to housebreaking, burglary and serious sexual offences. (Homicide is the only crime with which the Juvenile Court is not allowed to deal).
2. To deal with cases of boys or girls from 0 to 17 years, brought by the police or the N.S.P.C.C. as being in need of care or protection.
3. To deal with cases of children whose parents charge them with being beyond control.
4. To deal with cases of children of school age, who have become habitual truants, and whose parents have been convicted in the ordinary Magistrates' Court of neglecting to provide for the children's education.
5. To deal with applications for adoption orders.

The Court has, therefore, both civil and criminal jurisdiction.

In every case, the chief concern is to be the welfare of the child, but it is not in the interests of the child to do injustice, and if the case is one of theft or any other offence, the child must be given a trial as fair as that to which his elders are entitled, and the police (or other prosecutor) must prove their charges. In practice, most children brought before the Court admit the offence, but they should not be pressed to do so either by the police or by anyone else. They should have the charge explained to them simply, so that they really know what it is, and if there is any doubt as to whether they admit it, or if the parent does not agree that the child has committed the offence, then the Court should regard the plea as "Not Guilty" and require full proof by evidence in the usual way. This may mean that a Juvenile Court may have to acquit a small boy, who is obviously running wild and getting into habits of dishonesty, or is living in a thoroughly bad home, because there is not conclusive evidence of the particular theft of which he has been accused. The Court is not a welfare department, and it must not allow criminal charges to be used as a means to "do good" to a child. If the home conditions, the child's physical or mental well-being or its character make interference desirable, then the proper course is for the L.E.A., or the police, or the N.S.P.C.C. to bring the case up as needing care or protection.

Once the charge is proved, then the paramount concern is the child's welfare. There are four purely primitive measures open to the Court. The first is fining, which is a perfectly sensible way of dealing with a big lad, who has earnings or pocket money to pay the fine himself, and who rides without a light on his bicycle or regularly makes a nuisance of himself by taking possession of the swings reserved by the local bye-laws for the little children. The second is imprisonment, which is allowed only in the case of young people (14-17 years) who are certified by the Court to be too unruly or depraved to be kept in a Remand Home. This is a sentence which can bring nothing but evil, and it will doubtless cease to be legal when Parliament next amends the penal law. The third is detention in a Remand Home for not more than a month. There is practically nothing to be said in favour of this, and it is a misuse of the Remand Home, which makes it more difficult than ever to organise that institution satisfactorily. The fourth is birching (a maximum of six strokes, for boys 8-14 years only). This method was condemned by the Departmental Committee on Corporal Punishment, 1938, and was to be abolished in Sir Samuel Hoare's Criminal Justice Bill of that year. The bill was a "war casualty," but birching was becoming

obsolete before the war, and after a revival, 1940-43, has practically fallen into disuse since the famous Hereford Juvenile Court Enquiry, 1943, showed that the sentence could not be carried out without violating either the statutory rule that it should be inflicted immediately or the law which gives the child and his parent three weeks in which to appeal against any order of the Court. Examination of case histories made in various places has shown that birching is the method most frequently followed by a repetition of the offence—the high spirited naughty boy thinks that a good way of proving his pluck and maintaining his prestige among his lawless mates.

This ends the list of purely negative or clearly harmful orders which the law allows the Juvenile Courts to make. The same law has put into the hands of the magistrates a number of thoroughly modern tools for their job of manufacturing good citizens out of troublesome or neglected boys and girls. These "tools" are of three kinds. First, there is Probation, which involves a solemn undertaking by the child to mend his ways, under the supervision of the probation officer (a trained social welfare worker) whose task is to be a friend—candid, wise and reliable—to the child and to his family, to help them to help themselves and one another, and to ensure that if possible the child "makes a job of himself." In the background, supporting the authority of the probation officer, is the sanction of law, for if the child does not keep his promise—if his word is not his bond—and he behaves badly, he can be brought again before the Court by the probation officer, and may then be dealt with more drastically for the original offence. Probation is not a "soft option," unless it is carelessly used by the magistrates, or slackly carried out because of shortage of qualified probation officers. It is the first line of defence against crime, because it enlists the offender against the offence. It makes him carry out a small-scale exercise in self government. It looks not to past misdeeds, but to future achievement. It is used in the case of roughly half the young offenders dealt with in the Courts, and in much more than half the serious cases, for large numbers of less serious offences are met by simple "dismissal" or by binding over without supervision. As probation orders can be made in the case of young offenders, so supervision orders may be made in the care and protection cases, and the probation officer is the one to supervise and guide the child.

The second method is "Committal to the care of a Fit Person." This is what is generally known as 'boarding-out.' When the fault lies with the home rather than with the child, and when that home is so bad, through immorality, neglect, unkindness, ignorance or disease, that the child cannot be expected to develop satisfactorily there, it is necessary to remove him from his parents for some time. If a very small boy is concerned, it is undesirable to deprive him of the natural relationships of family life, the personal care and affection of a father and mother, and the forgoing of a family in the evening after the different daily occupations of its members. School is a second best, and the best school cannot give the intimacy and warmth even of a second best or a rather poor home. So the Juvenile Court is required in the case of children under ten to commit them to the care of a Fit Person rather than to send them to a school, unless there is some strong reason why it is impossible to find a suitable foster mother. Sometimes the little boy or girl can be taken happily into the home of a relative, an aunt or older sister or a grannie, but there is a difficulty sometimes in that no Government grant for maintenance is available unless the child is placed in the

charge of the local authority as the "Fit Person." In fact, owing to the difficulty in finding foster homes, especially for children with bad habits (*e.g.*, bed wetting) or a record of pilfering and lying, the boarding-out plan, excellent as it is in theory, is often hard to work in practice. Juvenile Courts have no machinery themselves for finding foster homes and, in the vast majority of cases so dealt with, the Court commits the children to the care of the Local Education Authority. This was the method used in the famous Hereford cases. Two boys, who were birched for one offence, were for a second offence committed to the care of the Herefordshire Education Committee. The Court which makes the order has no power to fix the period of committal; the custody of the child must, according to the Children and Young Persons Act, be transferred from the parent or guardian until the boy or girl reaches the 18th birthday. Long before that time, application may be made to the Court for the revocation of the order. The application can be made by anybody, the boy or girl, the parents or guardians, foster parents, L.E.A., probation officer, police—or just a friendly neighbour or person interested in the case and convinced that the order should be revoked. In the Hereford cases, the boys were happy and well cared for in the country foster homes in which they were placed, and it was said that the Hereford L.E.A. and the magistrates often used this means of dealing with children who were out of hand at home, and that the L.E.A. returned them to their own homes after a comparatively short period. But normally boarding out is intended for children with unsatisfactory homes, for whom foster parents with a continuing interest in the boys and girls are needed. Boarding out is specially suitable in the case of the younger children found to be in need of care and protection.

This was the arrangement made for the O'Neill boys, who were placed on a Shropshire farm in the care of the Goughs, who early in 1945 were convicted, the man of the manslaughter of Dennis O'Neill, and his wife of wilful neglect. The case and the Monckton Report upon it showed how dangerous boarding out can be, if the L.E.A. which accepts the guardianship of the child, and the L.E.A. in whose area it is boarded out (which may or may not be the same authority), do not observe all the safeguards necessary for the protection of the child. The failure of the officers who selected the foster home to "size it up" intelligently, their failure and those of subsequent official visitors to inspect the boys' bedroom, to see the children alone, or to pay surprise visits, the failure to visit within a month of boarding out and afterwards at least every three months—all these sins of omission made possible the months of neglect and cruelty culminating in Dennis O'Neill's death. It is obvious that, as boarding out in a happy home, with a loving motherly woman and a kind foster father (who have no temptation or inclination to make a profit out of the maintenance grant or exploit the children's labour) is the ideal substitute "home" for destitute or neglected boys and girls, so boarding out with the wrong folk and without safeguards may involve the worst cruelty and neglect, with the least hope of redress. For children are normally silent in their worst miseries, and they accept what happens as inevitable, especially when they have not learnt to know or expect happiness or security. Beyond the legal safeguards of statutory rules and local government and Home Office inspectors, is the safeguard of local interest and local public opinion. An isolated farm like the Gough's was subject to little of this unofficial supervision. Its 70



mortgaged acres and stock, with no hired labour, made the danger of exploitation obvious. The neighbours' suspicions may be a safeguard, just as they may be unfounded; but boarding out is only safe if the boys and girls are in frequent contact with other families in the neighbourhood, playing with the other children, going out to tea with friends and so forth. This cannot be provided by Act of Parliament. But if care is taken to board out in, or close to, villages or towns, and especially if groups of foster homes can be found in the same area, the dangers are lessened. On the official side, it is essential that every L.E.A., as guardian of children (either delinquent or "care and protection" cases) should have qualified women social workers to choose and inspect the homes.

It is not enough to observe the letter of the Rules (*e.g.*, against boarding out more than two children in one family, unless they are brothers and sisters; against placing in a family with more than four other children; against placing with a foster parent on poor relief or one with a criminal record; against placing a child without a medical certificate of fitness). All these rules are good, so are the requirements that the foster parent shall be of the same religious faith as the child, that the L.E.A. shall provide medical care and see that the child's teeth are looked after, and that the home shall be visited at least every three months. But all these things are little or nothing worth, without love on the part of the foster parents, and the L.E.A. needs to look for its foster homes through the eyes of people who know a loving kindly woman when they meet her, and who are not taken in by fair speech (sometimes she is not very soft spoken), or a bright kitchen fire and an egg for tea on the first day of visiting. "Roof spotting" for foster homes is a skilled job. Some L.E.A.s have an arrangement whereby they have the assistance of the Guardianship Branch of the National Provisional Council for Mental Health, whose officers are trained and experienced in the work, and are continually seeking and supervising foster homes in all parts of the country.

The third chief method, which the Juvenile Court may use for offenders and care or protection or "beyond control" cases alike, is training in an Approved School. This is an easy way out of a difficulty, because the school assumes responsibility, has more or less the equipment and resources it needs, and can keep a firm hand on the boys and girls day in and day out. It is the only solution in a case where the freedom of a probation or supervision order is too big a burden for the child to carry. It is, for instance, often unavoidable in the case of the over-sexed girl of 15 to 17, endangered thereby, and in wartime, drawn to the neighbourhood of camps and barracks like a moth to the candle. She may be committing no crime; she may be behaving perfectly "naturally" according to her "nature" which she cannot help; but she simply must be restrained to save her from disease and misery and the degraded life of a prostitute, from which it may become difficult for her to retrieve her freedom and find the home and husband which later on she will so ardently desire. Some of these girls may be able to control themselves with the aid of the probation officer to advise, restrain and encourage. For others it must be a Home or School, which can hold them even against their will.

There are different types of schools: Senior, Intermediate, and Junior for boys; Senior and Junior for girls. Some are run by L.E.A.s with a Government grant. Some are run by philanthropic and child welfare

societies (*e.g.*, the National Children's Home and Orphanage, the Church of England Temperance Society, Society of Friends, and Dr. Barnardo's) with grants for equipment, and a capitation fee for the maintenance of each child, half from the Exchequer and half from local funds. A child's parents may be ordered to contribute to its maintenance in school. Some schools specialise in gardening and farm work, some in woodworking, and there are a few nautical schools. In the Junior schools, the boys and girls of school age generally attend the local schools. The girls' schools have still, it must be confessed, regrettably little variety in training, and the emphasis is still very largely on laundry and domestic work. The L.C.C. had, before the war, one school for girls who were capable of, and therefore needed, secondary education, but Approved Schools make little provision for secondary education of the academic type, for which there is indeed very little demand amongst the boys and girls who come before the Courts. There is only one co-educational Approved School, and that is the Caldecote Community—a boarding school for children of working class parents with a difficult background—which provides a limited number of places for children committed by the Courts. It accepts only young children with a reasonably high level of intelligence, and can keep them right up to the leaving age of 19. In all Approved Schools, the children write to and may be visited frequently by parents, and may go home for holidays, if they and the home are good enough. But the Court in sending a boy or girl to an Approved School has no power to fix the period. In the case of a child under 14, the period is for three years or till the 15th birthday, whichever the longer; for those over 14, it is for three years or till the 19th birthday, whichever the shorter. If a boy or girl over 16 escapes frequently from a School, he or she can be sent to Borstal for two years by a Magistrates' Court. The school authorities may release the child on licence long before this, but the Court has no jurisdiction and the school retains the right to supervise and recall the child up to the end of the full period.

The Approved Schools have increased in number of recent years and their standards of efficiency and happiness have gone up. Many of them are in attractive houses in the country with large gardens and playing fields and fine workshops. The Cotswold School for boys, run by the C.E.T.S., is an outstanding example of first rate equipment and excellent staff. All are inspected by the Home Office which exercises very close supervision and is extremely interested in and proud of its schools.

The provision for delinquent children thus consists of, supervision by the probation officer, committal to a fit person, committal to an Approved School. The first gives John or Mary an ally and adviser, the second, a substitute home family, the third a boarding school. They should be used in that order of preference, for other things being equal and John and Mary being in possession of normally intelligent and affectionate parents, it is best to leave the family as an unbroken unit, giving it all the help with the health and educative services, including the Child Guidance Clinics. Nothing has been said here on the question of Remand Homes, but it is important to remember that no Court is omniscient, nor can the wisest J.P. know by looking at a child what is the cause of the trouble. So for the proper administration of the law the Magistrates must have time to think and the services of experts in child health and child psychology. There must be a centre to which the child can be sent for examination by experts and to

wait while reports on home and school records are collected. That place should be bright and cheerful and give the best possible chance to the observers to see the child as he is in normal life. That should be a main function of the Remand Home.

# Settling Down in Civvy Street

GENERAL SIR RONALD F. ADAM, BART., K.C.B., D.S.O., C.B.E.,  
*Adjutant-General to the Forces.*

## CIRCULAR TO REPATRIATES\*

*I hope you will be interested in this Pamphlet and you will find time to read it carefully.*

*Civil Resettlement Units are based on experience and trials. I trust they will be of real assistance in helping you to settle down successfully.*

**T**HIS pamphlet tells you about Civil Resettlement Units for repatriated prisoners of war discharged or released from the Service.

## WHAT IS A CRU?

CRU stands for Civil Resettlement Unit. It is a place where you can get the hang of things in civvy street before you actually leave the Army.

It aims at giving you the best possible start in your new life.

A CRU is run like a leave camp. There is no "training" in the military sense. The only parade is Pay Parade. Food and accommodation are above the ordinary barrack standard.

A CRU puts you in touch with civil life. There are visits and demonstrations at places of importance to you. There are films and talks about what has been going on. Advice is available from qualified experts on future employment, pay, family affairs, health, etc.

## WHAT WILL THE CRU DO FOR YOU?

Starting off in the Army was difficult at first. You had to find your feet in a completely new world where everyone except you seemed to know his way about.

\* We reprint in full, by kind permission of the Adjutant-General to the Forces, a brochure which was issued to Army repatriated prisoners of war from Germany on arrival in this country. A similar brochure was also issued by the R.A.F. but the Royal Navy who had, in comparison, a very small number of prisoners of war, arranged for personnel to be met at the ports and advised individually by special welfare officers.

Going back to civil life won't be so bad because you have been there before. You have your family and friends to help you. But you have been away for some years and there have been changes.

Changes have taken place in civvy street. Your friends have been engaged in war-work. Many are on jobs that didn't exist before. There are ration cards and wartime regulations. Your wives, mothers and sisters have carried the burden of war-work as well as the extra difficulties of wartime house-keeping.

It is a different world in many ways from the one you left.

You have changed too. You are older than when you joined the Army. You are more experienced. You have seen new countries and different people and you have looked at them through the eyes of a soldier instead of a civilian. You have a new outlook on civil life, a more developed outlook and quite possibly a better one than before.

But you will need time to find your feet again. Going back after all these changes will not be easy. You may make a few false starts. You may not get in touch with the right people straight away. You may feel confused until you have got used to civil life again.

It is to help you bridge this gap between the Army and civil life that CRUs have been set up.

### WHERE ARE THEY?

CRUs are being set up as quickly as possible all over the country. They are being placed close to the big towns. This keeps them in touch with local industry and social services.

If you attend a CRU you can go to the unit nearest your home. You will thus have a chance to study the best openings in your own district and get in touch with your own local organisations.

You can also get leave every weekend if you want it. (Friday evening to Monday morning). In certain cases, if you live near enough, you may have a sleeping out pass.

### HOW LONG SHALL I BE THERE?

The normal course lasts from four to six weeks, but it can be extended if required up to 3 months. If you want to leave earlier, you may do so. You are a volunteer for the course and may leave when you like.

### WHAT GOES ON?

The atmosphere at a CRU is half-way between the Army and Civil life. There are spring beds and you sleep in sheets. Meals are served at separate tables in the Dining Room. There are no guards or fatigues. Your only duties are to keep your bed and belongings tidy.

You can visit factories, technical schools, and offices. There are workshops, films and discussions. You arrange your day more or less for yourself.

You work from nine in the morning to five in the evening. You are not "got on parade" by the NCOs. But you will be expected as a matter of courtesy to be punctual.

After the day's work, if you do not wish to go out, there will be social evenings and entertainments. For these you may wear civilian clothes. Uniform only has to be worn while at work during the day.

### THE DAILY PROGRAMME AT A CRU

There is no reveille. Breakfast is at eight and work begins at nine.

In the morning there may be a visit to local factory where you can talk to the men at work. Or you may go to a Ministry of Labour Training Centre to find out about courses. You may go to an Employment Exchange and hear about prospects in different types of work.

In the afternoon there may be a talk. It may be on housing or furnishing. It may deal with jobs or with public happenings while you were away. Some will certainly deal with the post-war developments which we hope are going to lessen want and unemployment in this country of ours. All will be given by people who know their stuff.

There are workshops where a man may pick up tools again. There will be discussions on the talks or on other subjects. There will be some light physical exercises and opportunities for games for those who like them. There will be many films; some documentaries showing the main events of recent years and some of the hits you missed.

### THE CRU AND YOUR CIVIL JOB

Naturally, every soldier thinks about his job in civvy street. To many all their worries about going back to normal life are centred on this. Each CRU has a specially trained staff to help you about this.

You can discuss your case with them. Tell them about your former job, your Army experience, your ambitions. Ask their advice about your capacities. Discuss different jobs with them.

They will arrange for you to go and look at different jobs. They will show you what the Ministry of Labour can do for you. They will tell you about the possibilities of further education and training—perhaps a refresher course before you go back to your own trade or profession; perhaps a special course for those taking up a broken apprenticeship, or a correspondence course for those who want to better themselves.

You can consult an official of the Ministry of Labour—the body that actually finds you a job. He will know what jobs are open and what the prospects are. He will help you to decide whether to go straight to work or to take a course at one of the Ministry's training centres.

A CRU is not a job-finding agency. It does not train you for particular jobs. But it will help you to look around. It will advise you. And it will put you in touch with those who have jobs to give you. You can then decide on your job. The CRU makes it possible for you to make a good decision. It is an important decision because your future happiness depends on the job you take. And this affects your family besides yourself. You don't want to drift into a blind-alley job when you are really capable of something better. You don't want to take the first job that comes up because you can't afford not to. It is worth while getting all the help you can before you finally make up your mind.

### PAY

While at a CRU you will receive the usual pay and allowances for your War Substantive rank. Your stay there does not count against your final leave.

Each CRU will have a Royal Army Pay Corps Sergeant on the staff. He will help you with any tangles in your account. He will straighten out any disputed allowances, paid acting ranks, and the like. He will tell you about your gratuity and the final payment which you receive at the end of your final leave. He will also help you with questions about post-war credits, civilian income tax—Pay as You Earn (PAYE), etc.

This will give you a chance to put your money affairs or any other such matters right before you leave the Army.

### HEALTH

Each CRU has a doctor and medical staff. They can call on specialist advice where necessary.

If you are worried about your health you can consult the CRU doctor. It will not be like the old-time sick parade. He will investigate any symptoms and discuss things with you. He may be able to help you in lots of ways, for instance, about your suitability for a new line of work.

### CRU CIVIL LIAISON OFFICERS

Each CRU will have a woman on the staff whose job is to help you with any personal or family problems. She will have had experience in this type of work and special training for these units.

Because of long absence from home difficulties sometimes arise affecting housing or health or children. It may help to talk these things over with someone who has experience of what can be done. Specialist advice can be obtained from legal people, housing authorities or from some other organisation.

### WHAT CAN I LOSE?

Attendance at a CRU does not count against terminal leave.

It does not affect any claim you may have for a pension.

It does not let you in for more Army service.

It does not affect your reinstatement rights in your old job.

It may delay your return to civil life by a few weeks but you will be near home and you can wear civilian clothes.

These few weeks may make all the difference between success and failure in after life.

### WHAT CAN I GAIN?

The help of a trained staff in deciding on your civil job or the job you train for.

Specialist advice on financial legal or personal problems.

The opportunity of meeting civilians who can help you after you leave the Army.

A better chance of supporting your family if you start civilian life after you have looked round for a bit.

Specialised help if you are disabled.

The opportunity to try your hand at one or two things before making up your mind.

# Treatment and Resettlement of War Psycho-neurosis

EVERETT HOWARD, *General Secretary, Ex-Services Welfare Society, and Honorary Director, Thermega, Ltd.*

ON the outbreak of the present war our country had a legacy of 6,000 men in mental hospitals and over 30,000 suffering from varying degrees of neurasthenia and in receipt of pensions.

Since the present war, it is estimated that already 120,000 men and women have been invalidated from the services suffering from psycho-neurosis. It is also known that psychiatrists and neurologists are insufficient in numbers to cope with the demands made upon them both in and out of the services.

What was done for these people in the last war? Have we taken heed of the lesson learnt then? Let us examine the position.

During, and immediately after the great war of 1914-1918, the country, being totally unprepared then, as it was at the beginning of this war, was compelled to place our soldiers and sailors, rendered insane by war service, into what were then known as pauper lunatic asylums. But later, the titles "pauper lunatic asylum" and "pauper" were changed to "mental hospitals" and "private and rate-aided patients." With those changes, improvements were made in the conditions in those institutions, and medical men have since been appointed whose good work and capabilities cannot be over-estimated.

As an example of the state of affairs after the last war the following is significant: Of one mental hospital it was stated by the Board of Control in their official report, 1923: "None of the male patients are shaved and those who desire to be have to revert to the use of pumice stone. It is hoped that arrangements may be made for those men who desired to be shaved to be done, and with safety razors." In some asylums there was only one doctor to 600 patients. Such were, briefly, the conditions twenty years ago.

What are the conditions in 1945? A few weeks ago, correspondence was started in a weekly paper by a man who was suffering from a nervous breakdown and who had entered a mental hospital as a voluntary patient under the Treatment Act of 1930, which Act provides for people to enter an institution without being certified as lunatics. On arrival there, he was subjected to the most humiliating treatment, being placed among violent and certified lunatics. He ended his complaint by stating that the work of individual doctors could not be too highly praised, but the system and routine of the hospital could not be too strongly condemned; that he hoped that in the post-war planning the most helpless class of all will not be forgotten. We have before us a letter from a medical superintendent in which he states: "The above-named (an ex-Service man) was admitted here but handed in his notice of discharge almost at once. He expressed some resentment at being mixed up with certified patients and stated that the locked doors upset him." This is not an isolated case.

The question asked is, did Parliament intend, when passing the Treatment Act of 1930, that a person whose medical condition did not require him to be certified, be placed among people who are insane ?

It must not be assumed that many of the 120,000, or more, people suffering from the scourge of neurasthenia and mental trouble cannot respond to treatment and are incurable. With suitable treatment and guidance from understanding people, both medical and lay, a very large number of these sufferers can be restored to society and become useful citizens again.

How can this be done, provided accommodation can be found for patients ? With the phenomenal growth of that branch of medicine known as psychiatry, the mind of man is no longer to be regarded as a mystery. But with all possible skill and treatment medical men must have always in view the time when their patients reach a point in their recovery when they should be encouraged to perform some kind of occupation, however light it may be at the first stage. At this crucial stage, doctors should seek the opinion and advice of practical people well versed in the professions and industries for the purpose of extending the patients' attempts to undertake tasks which will develop a desire to do work of creative and remunerative value. At present the tasks given to most patients are of an amateurish and almost childish kind. This most important phase on the road to recovery is not considered with sufficient vision. Occupational therapy workshops in hospitals lead to boredom and discontent. Some are reminded of the "dole." With due respect for those who study psycho-neurosis, it may be claimed that a study of the psychology of the public mind would be of service. Technical advisers, with long and wide experience of men, should be of the greatest value to psychiatrists, if collaboration was sought and pedantic theory was set aside. Such collaboration would lead to the increased knowledge by the doctor of industrial life, to the benefit of the patients when they are ready to enter a new world. For it *will* be a new world to many young men and women who, through the many Government schemes and opportunities in commercial and professional life, may be trained and directed into occupations chosen by themselves, instead of as heretofore, being compelled through force of circumstances to take up uncongenial and unsuitable occupations.

With regard to patients who are in hospitals, more advanced courses of practical training of the individual kind should be introduced under the eye of a technical adviser who would always be in touch with the Ministry of Labour and, through them, with the industrialists. Such a practical arrangement would prevent supposedly recovered patients being presented to Labour Exchanges and *not* directly to employers.

The grading of patients for employment should also be done by a doctor and technical man in consultation before the patients leave hospital, and it is suggested that the following grades should be adopted :

- (1) those who go straight into industry or the professions.
- (2) those who go to a Government training centre.
- (3) those who go to sheltered industries, which should be established on a more or less self-supporting basis without exploitation of service or disablement.
- (4) those who are unemployable.

The Ex-Services Welfare Society was founded by the late Sir Frederick Milner in 1918. It was reorganised, with the help of Lord Horder, in 1922.



It is the only organisation which deals entirely with ex-service men and women of all ranks who suffer from neurasthenia or nervous breakdown. It has demonstrated that these cases can be guided into industries which make them self-supporting and useful citizens again. The Society operates throughout the British Empire and works in co-operation and harmony with all other organisations. An average of 9,000 advisory interviews are given each year with a view to helping ex-service men to obtain employment. The Society has departments to deal with all problems—problems of pensions and relief, legal and rehabilitation, medical advice and treatment.

A particularly significant and successful experiment has been developed to help the third group of ex-service men, those who are employable only in a sheltered industry. An industry was created for this purpose sixteen years ago. It operates apart from charity and is self-supporting. The business men on the committee considered that when patients were discharged by medical men, these patients should no longer receive treatment. They agreed that the Society's newly acquired property should be definitely and separately developed as an industrial colony away from the treatment centre and that, as a matter of principle, the industrial colony should not assume the character of an institution or sanatorium, but become a workshop pure and simple, in combination with a hostel: a sheltered industry which would remove the men's products from the competition of the open market. The Society, having isolated its industrial side from charity, then decided to establish a private company (Thermega Limited) the entire shares of which belong to the Society. This industry, the manufacture of electrically heated pads, blankets, etc., was chosen, first because it was a fairly non-competitive one (the patent having been bought by the Society) and secondly because there was an opportunity for many different types of work in its manufacture. There is an overwhelming demand for this article. The employees live in the Society's hostel at Leatherhead, where there are full social amenities—club rooms, gardens, etc. They work for a fair wage in every stage of the manufacturing process—electrical work, engineering, tool-making, book-keeping, accountancy, etc. There are also cottages owned by the Society for married employees. Two thousand ex-service men have passed through its curative centres and this sheltered industry to outside employment. This is merely a demonstration of the possibilities of this principle. As already stated, while the employees are working in the industry, they are *not* given medical treatment (except for ordinary emergencies) as it is considered that the stage has been reached when they can support themselves, with the aid only of the security given by the community life of the hostel and club.

The Directors (mostly business men) who are members of the committee receive no fees or emoluments, and as all the shares are held by the Society, the profits accruing from the sale of the goods produced partly enable the company to pay the men a living wage. The advantages of adopting the title of a private company were three-fold: (1) psychologically, the men felt they were not working for a charity, (2) their products were made and sold through ordinary business channels, and (3) when the men find employment outside they receive a testimonial on the firm's notepaper and thus no reference is made to their past disability. There was to be no exploitation of the men's service nor of their disablement, and they were rendered self-supporting by making something of real commercial value.

The Ex-Services Welfare Society feels, with its knowledge and its contact with Government Departments, that in many cases mental hospitals and neurosis centres should be overhauled and modern treatment and better classification methods introduced into many of them. Instead of the "Occupational Therapy Workshops," which in many cases are mere sheds with lack of accommodation and uninteresting work, there should be properly lighted buildings, a number of practical instructors and an adequate supply of tools so that a real incentive can be instilled into the minds of those who are on the road to recovery and who can later be dealt with by the Ministry of Labour.

To sum up, as in 1918 so now, it is the responsibility of this country to provide for the men and women who have been incapacitated by nervous and mental illness as a result of the war. It is not only necessary to provide hospital treatment, but also the best medical treatment available, and then training in the right type of work for each man. Much will have to be done to fulfil this responsibility. The mental hospitals and psychiatric services throughout the country need thoroughly reorganising and especially do they need a much more adequate medical and nursing staff. An existing organisation, such as the Ex-Services Welfare Society with its long and wide experience, supported by other organisations, should be invited by the Ministry of Health to co-operate in restoring to work the highest possible proportion of men suffering from these illnesses. Industries throughout the country should be invited to take part in this scheme, to enlarge the scope and type of experiment which proved so successful at the Society's industry at Leatherhead, so that ex-service men and women can be employed in somewhat sheltered conditions in many industries, before competing fully in open industry. In this way we can hope to avoid the terrible legacy of developed chronic invalids which followed the last war, and repay the debt which the community owes to these men and women whose personalities have been damaged in defending it.

# The Public Health Services of London

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## Introduction.

THE term "London," which was originally confined to the ancient City of that name, is to-day used loosely to describe not only the City and the Administrative County of London but is also employed in connection with a number of larger areas for a variety of purposes, *e.g.*, police and transport.

If the question was asked, what is the population of London, quite a common reply would be that it was about eight and a half millions. That certainly was the estimated pre-war population of Greater London, a term generally used to connote the Metropolitan Police District which extends roughly to

a radius of 15 miles from Charing Cross and covers an area of 693 square miles. Within that area there are upwards of 200 local authorities and, incidentally, it is, in the voluntary hospital field, the area embraced by the King Edward's Fund for London.

This article, however, only attempts to deal with the public health services provided primarily for the inhabitants of the administrative county of London, an area of 117 square miles, with an estimated pre-war (1938) population of about 4,100,000 and a total rateable value of £61,582,000—the product of a penny rate being about £255,000.

### **The Local Health Authorities : Their Powers and Duties**

The authorities which exercise jurisdiction (including the provision of health services) within the administrative county, are 30 in number and comprise the London County Council, the City of London Corporation and the 28 Metropolitan Borough Councils (including that of the City of Westminster).

The constituent areas of the administrative county (and their residential pre-war populations) range between a square mile (population 9,380) in the City and less than a square mile (406 acres) in Holborn (population 34,600) to 14 square miles in Wandsworth (population 341,700) and five square miles in Islington (population 295,400).

The public health administration in London, although somewhat simplified by the Local Government Act, 1929, still remains complex. The Act abolished the 25 metropolitan boards of guardians and the Metropolitan Asylums Board with the result that some 80 hospitals, previously administered by those bodies, were brought under the control of the London County Council and welded, with its 15 mental hospitals and institutions, into one municipal hospital system.

The Metropolis sometimes has a special Act and often one or more special sections in general Acts. This is because the administrative structure of metropolitan government is unique. For example, the London Government Act, 1939, in addition to defining the administrative county and laying down the constitution, etc., of the County Council and the Metropolitan Borough Councils, also contains the statutory provisions for the appointment of the county and borough medical officers of health and borough sanitary inspectors. (The rights and privileges of the City which originate from a Charter of William the Conqueror, are contained in separate enactments.) London has also had, since 1891, its own public health Act, the latest being the Public Health (London) Act, 1936. (The Public Health Act, 1936, *i.e.*, the Act which governs the rest of England and Wales, does not, except where expressly provided, extend to London.)

The London County Council's administration includes the main municipal hospital and ancillary services (including general and accident ambulance services), the mental health services, the school medical service, the venereal diseases scheme, the Welfare of the Blind scheme and the public assistance service (which is centred in the Council's Social Welfare Department). These services, with the exceptions in the case of the City mentioned below, cover the whole administrative county. On the other hand, while the County Council is responsible for the preparation of bye-laws on various general public health matters concerning general sanitation and environ-

ment, the requirements (with one exception referred to later) are actually administered by the Borough Councils who, with the City Corporation (acting through its Common Council), are the local "sanitary authorities" responsible for administering the sanitary provisions of the Public Health (London) Act, 1936. (The Borough Councils also have health functions under various other Acts.).

There are certain services in which both the County Council and the Borough Councils are concerned, *e.g.*, control of infectious disease, drainage, housing, maternity and child welfare, provision of open spaces, treatment of tuberculosis. Broadly speaking, the larger schemes are dealt with by the County Council, *e.g.*, it is the main drainage authority while local drainage is the concern of the Boroughs; and, in the provision of open spaces, the Council was responsible, in 1935, for launching the "Green Belt" scheme, which through joint action with the home counties' authorities has already been so largely realised.

The City Corporation is in an exceptional position in London since it can itself exercise practically every health function of the County Council and all the health functions of a Metropolitan Borough Council. It makes its own provision for the mentally disordered, for tuberculosis dispensary work and for the treatment of venereal disease. It maintains an accident ambulance service and, as will be seen later, it acts as Port Health Authority for the Port of London.

Mention of the exceptional position of the City calls to mind bodies formerly known as the "chartered liberties," *viz.*, the Inner and Middle Temples, Lincoln's, Gray's, New, Staple and Furnival's Inns, Charterhouse and the precincts of Westminster Abbey, each of which formerly had its own local government. Of these, only the first two remain independent to-day. The position of the Temples, which are included within the City's "square mile," presents an interesting historical survival since, while for some purposes they appear to be within the City's jurisdiction, for other purposes they are outside it and, for example, appoint their own (part-time) medical officer of health.

An important part in the co-ordination of the work of the Borough Councils is played by the Metropolitan Boroughs' Standing Joint Committee constituted of representatives of the City Corporation and each Borough Council. This body deals in an advisory capacity with questions affecting the Boroughs as a whole and is also consulted by Government departments and the County Council on legislative and administrative proposals.

No mention has so far been made of one important service, *viz.*, that of water supply. The County Council, unlike provincial, county and county borough councils, etc., possesses no powers in this direction, the supply of water being the function of the Metropolitan Water Board whose area of supply covers 573 square miles and embraces, in addition to the whole of the administrative county, large parts of the adjoining counties of Essex, Hertford, Kent, Middlesex and Surrey. The County Council is, however, represented on this Board and also on the Thames and Lee Conservancy Boards from which rivers, are drawn respectively about five-eighths and one quarter of London's domestic water supply.

In the review which follows space will only permit of a somewhat more detailed reference to the functions, and a brief description of the working, of some of the main services referred to above.

### **General Sanitation and Environmental Services.**

The County Council's functions in this field are generally of a regulating and supervisory nature. For example, it has power to act in default of a Borough Council in certain matters and it bears on the county fund half the cost of the salaries of borough medical officers of health and borough sanitary inspectors. The numbers of the sanitary inspectors, which are subject to the approval of the Minister of Health, may be increased by him at the instance of the County Council or of the Borough. On the other hand, the active field work is the function of the Borough Councils. Their numerous functions include (i) ascertainment and abatement of nuisances and enforcement of their own and the County Council's bye-laws for the prevention of certain classes of nuisances ; (ii) cleansing of streets and removal of street refuse ; (iii) removal of house refuse, securing and emptying of ash bins, etc., and enforcement of the County Council's bye-laws as to water closets, etc. ; (iv) provision and regulation of use of public lavatories and sanitary conveniences ; (v) construction and maintenance of local drains and sewers ; (vi) provision of public mortuaries ; and (vii) enforcement of the County Council's bye-laws as to child life protection ; common and seamen's lodging houses ; cowhouses ; offensive trades ; protection of food ; slaughter houses ; tenement houses, etc. (In the matter of nursing homes, the County Council is, however, not only the registration authority but, in addition to making bye-laws, it also acts as the supervisory authority for the County.)

### **Control of Infectious Diseases.**

In the control of infectious diseases, the functions of the County Council and the Borough Councils are mainly complementary. The County Council provides the infectious diseases hospital accommodation and, as local education authority, it endeavours, through its school medical service, to control the spread of infectious diseases in the schools. The Borough Councils deal with the control of infectious diseases in the homes and workplaces of the whole community, including the homes of school children. Consultant assistance from the County Council's staff is available, on request, to the borough medical officers of health in the diagnosis of doubtful cases of fever and smallpox.

The Borough Councils provide means and premises for the disinfection or destruction of infected articles ; the cleansing and disinfection of premises ; and the compulsory removal to hospital under a Justice's order of an infected person who is without proper lodging or accommodation.

Both the County Council and the Borough Councils have power within their respective areas, and with the sanction of the Minister of Health, to make temporary or permanent orders adding to the number of notifiable infectious diseases.

Notification of infectious diseases is made to the Borough Councils whose officers make the necessary enquiries at the home of a patient into the source of infection. The movements of persons who have been in contact with infectious disease are followed up and, where necessary, information regarding such persons is supplied to the medical officers of health of other districts. Copies of notifications are sent by the borough medical officers of health to the County Medical Officer of Health who, when

necessary, undertakes enquiries into the conditions giving rise to undue or widespread prevalence of infection.

The public vaccination arrangements are wholly in the hands of the Borough Councils who also provide diphtheria immunisation clinics and supply diphtheria antitoxin to medical practitioners for the poorer inhabitants of their districts. Much immunisation against diphtheria is, however, done in the schools.

### **Tuberculosis.**

The County Council's tuberculosis scheme for the whole county (excepting the City) includes provision for treatment of the disease in all its aspects, free of charge to the patient.

The scheme involves the maintenance by the Borough Councils (with financial assistance from the County Council) of 33 tuberculosis dispensaries which act as centres for diagnosis and after-care ; for the examination of contacts ; and for publicity. The administrative direction of the dispensary service is in the hands of each borough medical officer of health. The borough tuberculosis officers work in co-operation with the medical practitioners of their area and their services are available for consultations ; they also act as honorary consultants on the staff of the County Council's general hospitals which serve their area. The dispensaries are also linked with hospitals for special services such as x-ray examinations and artificial pneumothorax refills, for dental treatment and for other special purposes, though an increasing number of the tuberculosis dispensaries have their own x-ray plants and provide a widening range of service.

The County Council arranges for all residential accommodation required under the scheme, utilising about 2,200 beds in its own hospitals and sanatoria and leasing some 1,350 beds in voluntary hospitals and sanatoria, etc. It also provides open-air schools for children who do not require treatment in a sanatorium.

After-care is mainly the function of the borough dispensary services which operate either through tuberculosis care committees, composed of various voluntary social service agencies in the borough, or through specially appointed welfare officers.

During the war the County Council has made a good start on mass radiography. In the matter of the war-time measure for the payment of maintenance allowances, for persons undergoing treatment for pulmonary tuberculosis and their dependants, while the County Council is responsible for, and is carrying out the assessment of allowances, the machinery of the borough dispensary service is being used as far as possible for enquiries and for the actual payment of allowances.

### **Venereal Diseases.**

Under the London and Home Counties scheme, in which the County Council acts as manager and is joined with the County Councils of Buckingham, Essex, Hertford, Kent, Middlesex and Surrey and the extra-metropolitan County Boroughs of Croydon, East Ham and West Ham, the necessary facilities are provided for diagnosis and treatment of venereal diseases free of charge. The London County Council maintains the Whitechapel Clinic, the largest in London, and the Endell Street Clinic, and subsidises 16 clinics at voluntary hospitals.

### Port Health Authority

The important work of health administration in the Port of London is carried out by the Common Council of the City of London which, under the Public Health (London) Act, 1936, is the Port Health Authority for a district extending from Teddington Lock on the west, to an imaginary line drawn from Havengore Creek in Essex to Warden Point in the Isle of Sheppey and including also the eastern end of the river Medway; and generally exercises the powers of a sanitary authority for the district in question. In order to prevent the importation of infectious disease, vessels arriving in the Port are boarded at Gravesend by Port medical officers and sanitary inspectors and a small isolation hospital (closed during the war) is provided at Denton near Gravesend. An important function of the Port Health Authority is the inspection of imported food. Rigorous measures are also enforced for the repression of rats in the Port district and on vessels in the Port.

### Hospitals and Allied Medical Services

**Municipal Hospital Provision:** Apart from a small amount of special provision by the City Corporation and the Borough Councils (to which reference is made elsewhere), the main municipal hospital provision in London is made by the County Council which provides what is probably the largest hospital services in the world directed by a single authority. If three war-time neuro-psychological emergency hospitals (1,550 beds) are included, this service embraces 100 hospitals with a total bed accommodation of over 73,000 and a staff of upwards of 33,000. These hospitals comprise:

				<i>Normal bed accommodation</i>
27 acute general hospitals	..	..	..	16,456
13 hospitals for chronic sick	..	..	..	5,047
17 hospitals for infections (fevers, etc.)	..	..	..	9,236
6 tuberculosis hospitals and sanatoria for adults				1,494
8 hospitals for children	..	..	..	3,291
2 hospitals for sane epileptics	..	..	..	755
3 convalescent hospitals	..	..	..	923
24 mental hospitals, etc.	..	..	..	36,154
<hr/> 100				<hr/> 73,356

During 1938, the last normal year before the war, roughly a quarter of a million patients were admitted to the Council's hospitals which cater for all types of ailments. In addition, during the same year, over 21,000 infants (or 37 per cent. of all births to mothers resident in the metropolis) were born in the maternity wards of the general hospitals.

To the Council's hospital service are linked the other main health and ancillary services, briefly described below, for which the Council is responsible. Such a service permits of a high degree of specialisation and among the special units, etc., provided in the general and special hospitals, are those for chest surgery, diabetes, fractures, gastric cases, plastic surgery (removed outside London during the war), puerperal fever, rheumatism, thyroid disease, urological diseases, etc., and, among the more

uncommon diseases, post-encephalitis lethargica, trachoma and ophthalmia neonatorum. The Council provides at two hospitals, Hammersmith and Lambeth, special radium and x-ray therapy departments and, since January, 1942, Hammersmith hospital has housed the radio-therapeutic research unit (formerly at the Radium Institute) which is carrying out, under the Medical Research Council, an investigation into the comparative effects of radium and x-rays in the treatment of cancer of the mouth and throat. Special treatment which the Council cannot give in its own hospitals (*e.g.*, spa treatment for rheumatism) is provided by sending the patients to appropriate hospitals.

The wideness of the field over which these hospitals operate has naturally drawn attention to their importance as training grounds for the medical profession and the Council has made extensive provision in this direction. Apart from the mental hospitals which are separately dealt with later, extensive linkages existed before the war between the Council's general and special hospitals, and the London voluntary teaching hospitals, particularly in undergraduate instruction in obstetrics and fevers, etc. Special arrangements were made for post-graduate medical education. In the latter field, the British Post-Graduate Medical School, which was established at the Council's Hammersmith Hospital in 1935, represents the first instance of a teaching school being based on a local authority general hospital.

The steps taken by the Council in peace-time in moulding and extending its large hospital service have borne fruit in war-time. Not only have all the demands made on its hospitals for the treatment of normal illnesses been met, despite heavy bombing of its hospitals, but approximately half the London air-raid casualties requiring admission to hospital were taken to its hospitals. On the medical education side the Council, during the war, has met many demands to provide systematic instruction for medical students in its hospitals owing to the evacuation of patients from the London voluntary teaching hospitals. To meet the needs caused by the dispersal of students, the Council has provided in many cases residential accommodation within its own hospitals, much of it necessarily improvised, for students.

### **District Medical and Nursing Services**

The Public Health Acts do not contain any general powers for the domiciliary attendance of the sick and the responsibility for administering these services, the continuation of the old "parish doctor" system, falls on the County Council under its Poor Law powers. There are 88 medical relief districts in the administrative county; 78 are at present served by 73 part-time district medical officers (general practitioners) and the remaining ten districts by the full-time staff of ten of the Council's general hospitals. The Council pays a large subsidy for district nursing to voluntary nursing associations.

### **Maternity and Child Welfare**

Under the Public Health (London) Act, 1936, the "welfare authorities" for the purposes of maternity and child welfare and of notifications of birth, are the Common Council of the City Corporation and the Borough Councils. Amongst the services which they provide, either directly or by arrangements with voluntary organisations, are those of health visitors, child welfare centres, ante-natal clinics, supply of milk and meals for expectant and nursing mothers and for young children, and day nurseries.



The County Council under its hospital powers, as already indicated, undertakes a large amount of institutional midwifery work and also provides ante-natal clinics. It is also the local supervising authority under the Midwives Acts and is the local authority entrusted with the provision of the domiciliary midwives service in London. Some 31 voluntary organisations, of which 15 are hospitals (including nine of the teaching hospitals) and 16 district nursing associations, provide midwives under the County Council's domiciliary midwifery scheme in addition to those provided by the Council itself. The County Council provides residential nurseries under its Poor Law powers.

Under the Public Health (London) Act, 1936, the City Corporation and the Borough Councils possess similar powers to the County Council to provide, or arrange for, hospital accommodation. Although they have not used those powers to make any substantial direct hospital provision, seven Borough Councils had, by 1938, each provided a small maternity home (the total accommodation of these seven homes amounted to 155 beds) and in one case (Fulham) there was an infants' hospital of 21 beds. (Of these, owing to the war, only two maternity homes, at Fulham and Wandsworth, are at present functioning.) In addition to the County Council's provision for convalescent adults and children, small convalescent homes have been provided by one or two Borough Councils for ailing children under five years of age. Both the County Council and the Borough Councils make use of, on payment, beds provided in voluntary convalescent homes and maternity beds in voluntary hospitals, in addition to subsidising voluntary hospitals and associations in respect of maternity and child welfare services provided by them.

The ante-natal clinic arrangements provide an interesting example of duplication of powers, *e.g.*, in the provision of food at the public expense. Under their maternity and child welfare powers, the Borough Councils can provide extra nourishment for necessitous expectant and nursing mothers and also for young children. The County Council cannot itself provide extra nourishment for such persons except under the Poor Law powers to relieve destitution. It may, however, under the Public Health (London) Act, 1936, make arrangements with a Borough Council (as a welfare authority) for such provision and, in practice, this is generally what is done.

On reaching school age a child passes out of the purview of the Borough Council as a welfare authority and into the care of the County Council as education authority. The position in this respect is thus different from that in County Boroughs outside London where the same local authority is responsible both for the maternity and child welfare and school medical services.

The functions which were formerly exercised by the County Council as the local authority (outside the City) for child life protection (*i.e.*, the supervision of the reception and maintenance of children under nine years of age by foster parents for reward) are now the responsibility under the Public Health (London) Act, 1936, of the City and the Borough Councils.

### **School Medical Service**

The County Council's school medical service provides for the medical examination at three or four definite periods of school life (according to the nature, secondary or elementary, of the school attended) of all children

in its schools. Close watch is kept at other times on their health and special treatment is provided when necessary.

There is a close link between the child welfare centres provided by the Borough Councils and the 70 or 80 school treatment centres—provided by local voluntary committees but mainly financed by the County Council. Immediately before the war the large medical staff employed by the Council on school inspection work and at treatment centres included extensive specialist and consultant provision. In addition to comprehensive facilities provided in special schools for children unable to take part in normal school life, provision for hospital treatment concurrently with educational provision is greatly facilitated by the Council's possession of large children's hospitals with schools attached. A notable instance is the special provision made for rheumatism, probably the most crippling and invaliding of all the diseases of school life. This is now dealt with on preventive lines and, by 1938, the Council had set aside 800 beds in its country hospital schools for the purpose.

### **Mental Health Services.**

The County Council and the Common Council of the City of London are the "local authorities" in London for the purposes of the Lunacy and Mental Treatment Acts. Apart from a 660 bedded mental hospital provided by the City, out-patient provision and a small number of beds provided by voluntary agencies, all the public provision for mental health in London is made by the County Council.

The County Council's mental hospitals fall mainly into two classes, *viz.* (i) those provided for mentally disordered patients dealt with under the Lunacy and Mental Treatment Acts; and (ii) those provided for mental defectives under the Mental Deficiency Acts.

Attached to certain of the Council's general hospitals are mental observation wards; these units are peculiar to municipal hospitals and are part of the machinery of the Lunacy Acts. Specialists from the Council's mental hospitals act as consultants to these units and also at psychiatric out-patient clinics which are attached to three of the general hospitals. There is also a considerable amount of provision at one mental hospital for uncertified senile patients.

The Council's Maudsley hospital is an important research centre in psychiatry and has two University of London Chairs, in clinical psychiatry and mental pathology. This hospital (originating from the gift of Dr. Henry Maudsley, the distinguished psychiatrist) represented a new development in the treatment of mental disorders and by its opening, in 1915, anticipated by some 15 years the reception of "voluntary" patients provided for in the Mental Treatment Act, 1930. Patients have never been received at this hospital under orders of compulsory detention. This means that early cases form the great majority of the number treated there and there has been a most satisfactory rate of recovery.

The Mental Deficiency Act, 1913, separated and specialised the care of the mentally defective and thereunder it became the County Council's duty to ascertain what persons within the county are mentally defective from birth, or from an early age, and to provide a suitable form of care. The three recognised forms of care in operation are (a) supervision in the defective's own home; (b) guardianship in the care of some private person and (c) care

in a certified institution. The "ascertaining" of mentally defective school children is dealt with under the school medical service.

As in the last war, the number of mental patients requiring treatment has during this war shown a continuing downward trend. Though by no means an offset, this is a fortunate occurrence as, since the outset of the present war, 25 per cent. of the bed accommodation at the mental hospitals (including one 2,000 bedded hospital) has been turned over for emergency hospital purposes.

The Council's large mental health service offers unrivalled opportunities for studying all types of mental illness. Lecture demonstrations to medical students are given at most of the mental hospitals, and for post-graduates extensive provision has been made at the Maudsley hospital. With the closing of the Maudsley hospital to in-patients in war-time special provision for post-graduate medical education has been continued at two of the three special emergency hospitals already mentioned.

### **Pathological and Laboratory Services**

Extensive pathological services have been developed in connection with the County Council's hospitals services. These comprise, for the general and special hospitals, seven group laboratories, a central histological laboratory and a large number of hospital laboratories, and for the mental hospitals, a central pathological laboratory.

These services have made a substantial contribution to the war effort. Not only have the emergency laboratories set up by the Ministry of Health in London and the provinces been extensively supplied with media and other laboratory products and equipment, but the Council's laboratories have also supplied similar products to the Army and other Government departments and also to some of the Allied Governments.

The County Council also maintains a central and two branch chemical laboratories for investigations into water, milk, etc., and other materials submitted for analysis from its various services; for examination of air in the road tunnels under the Thames and in connection with atmospheric pollution in London and other areas; and for analytical work, etc., in connection with its main drainage system.

So far as the Boroughs are concerned, some boroughs make use of laboratories at voluntary and municipal hospitals, some use commercial organisations and others undertake at least some of the work by using their own staff.

### **Conclusion**

From the above very brief description of the public health services of London, it will be realised that it is a complex administrative structure but, in practice, the results of public health work in London have not been unsatisfactory. We cannot, however, rest on our oars, and still greater improvements in the health of Londoners may be anticipated if, and when, an effective national health service materialises.

# Medical Services in the United States

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COMPULSORY health insurance systems set up in most industrialised countries throughout the world to provide medical service and income in times of sickness for their population, are lacking in America. In the United States, compulsory health insurance is mainly in the stage of proposals. Only under workmen's compensation laws is medical care provided for the victims of industrial accidents or diseases, and only one State—Rhode Island—gives cash benefits for temporary sickness to working people covered by the State unemployment law. During the last two years, health insurance legislation has been under consideration and discussion in the United States as well as in Canada, but unlike Canada, whose medical profession advocates such legislation, organised medicine in the United States is bitterly opposed to any changes in the old pattern of medical services.

Lately, the centre of attention focussed round the Wagner-Murray-Dingell Bill, which originated with organised labour and which was introduced into Congress in June, 1943. Besides proposals to improve and extend existing social security provisions, the Bill will establish a national system of compulsory medical insurance for: All persons employed for wages or salaries; employees of industry, commerce, non-profit organisations, farm and domestic workers; all self-employed persons, such as store-keepers, independent professional people, farm operators, etc.; and for the dependent wives and children (under age 18) of the employed and self-employed. States, counties, cities and other branches of local government would be permitted to enter into contracts with the health insurance authorities to provide the same benefits for public employees and their dependants; the same might be done for "welfare" clients.

In addition to medical services, employed persons would have a right to receive cash benefits during temporary illness (lasting less than 26 weeks), and employed and self-employed persons would receive invalidity pensions in case of permanent disability (sickness lasting more than 26 weeks).

The following medical and allied services would be provided:

1. Medical care by general practitioners.
2. Care by specialists.
3. Hospitalisation for 30 days (which later may be extended to 90 days).
4. Necessary laboratory or related services, supplies and commodities on direction of a physician.

Dentistry and home nursing are not included; medicines may be provided during hospitalisation and in connection with "laboratory benefits." Studies would be made for the purpose of including dental and nursing services within two years. Doctors would be paid either according to a fee schedule detailing all possible services (fee-for service), or on a *per capita* of patients basis, or on a salary, or by combinations of all three methods.

To finance these services and the cost of their administration, a special "Medical Care and Hospitalisation Account" will be established. Three

per cent. of wages or earnings of insured persons (not of dependent family members), calculated on their income up to \$3,000 a year, would be earmarked for this fund. (On the average, the American people now spend about three per cent. of their incomes for physicians' and hospital service, and the lower income groups spend an even larger proportion).

The national authority administering these services is to take into account several general principles assuring the maintenance of high quality of care under the programme, of freedom of choice for the patient, and of professional freedom for the physician. Standards would be established for hospitals, and if they are to participate, their professional service, personnel, and equipment must be adequate for the health and safety of the patients.

In addition to medical care, hospitalisation, and cash disability benefits, the Bill would provide for grants-in-aid to non-profit institutions and agencies engaged in research or in professional education.

Congress did not take any action on the Bill, for which no campaign to promote its passage had been planned by its advocates. It had been introduced mainly for the purpose of serving as a basis of discussion of the problem of adequate social security, and especially of adequate medical care for the American people.

The American Medical Association and the State and county medical societies led the opposition against the Bill. The National Physicians Committee for the Extension of Medical Service, set up a few years ago separately from, while officially approved by the Association, to combat any health insurance proposals, and financed partly by physicians and partly by the drug business, spared neither time nor money to conduct a widespread newspaper and speaking campaign. The Surgeon General was assailed as the future "dictator" of the medical profession, the medical care proposals were labelled "socialised medicine," and other fallacious statements were made. The effect was that public curiosity became aroused, and that friends and foes of health insurance competed in advertising the subject matter of the Bill among the people.

Two, numerically small but professionally significant, committees of physicians and some individual independent physicians endorsed the Bill in principle, and from them and other groups (lawyers, etc.) came suggestions for the improvement of its medical care proposals. In the Fall of 1944, a new nation-wide health programme was formulated at a Health Programme Conference, which consisted of a group of progressive physicians, who had joined forces with a group of economists and administrators, and the research directors of the two federations of labour. The main improvements asked for were: Decentralised administration of services and local responsibility under national standards; provision that policy on both national and local levels shall be determined by representative groups, in which there is participation of the people who receive, and the professions and agencies that furnish the services; aid for the construction and improvement of hospital facilities, especially in rural areas; encouragement of hospitals as medical service centres and of group medical practice.

At the same time, the American Public Health Association, whose membership consists mainly of public health officers of government and private health agencies, came out for a comprehensive nation-wide programme of medical care. Its report reviewed the extensive deficiencies existing in the physical facilities, the number and distribution of personnel required to

provide preventive and curative services, and emphasised that a large portion of the population to-day is receiving "insufficient and inadequate medical care."

That the health of Americans is nothing to boast about, despite the tremendous advance in medical science, came as a great shock to the nation when the medical findings of Selective Service examinations were made public, at the hearings before the Senate Committee on Wartime Health and Education, under the chairmanship of Senator Claude Pepper of Florida. Out of 13 million men drafted, four million were rejected as unfit for military service, of whom one sixth suffered from "easily remediable defects" and a larger number from defects that were preventable. Other data concerning high maternal and infant mortality rates, and the mal-distribution of medical resources, were brought out strongly by medical officials and prompted the Committee to make proposals to remedy the situation. The Committee suggested the establishment of a chain of regional medical centres, around which hospitals and other medical care institutions would be clustered, with all laboratory facilities needed for practice and research, as well as schools for nurses, resident physicians and post-graduate students; it further endorsed federal grants-in-aid for medical research, extension of preventive medicine and of sanitary facilities.

The facts revealed at the hearings of the Pepper Committee have dramatised medical needs to millions of people, who had never heard of the surveys and studies of the state of health of the American people previously undertaken. At the end of 1932, the Committee on the Cost of Medical Care, after extensive research to establish the facts about the organisation and economics of medical services, presented its recommendation of health insurance and group medical practice. Two years later, the American Medical Association, which had attacked these conclusions, successfully opposed the inclusion of health insurance in the draft of the Social Security Act. In 1935-36, a National Health Survey conducted by the United States Public Health Service in co-operation with other federal agencies, confirmed the previous findings and supplied fuller data as to the nature and extent of disabling illness. The National Health Conference of July, 1938, presented these findings, together with recommendations for federal aid, to the states for the establishment of compulsory disability insurance systems, hospital construction, public health purposes, and the extension and improvement of public medical care for needy persons. In 1939, Senator Robert F. Wagner incorporated these proposals into his "National Health Act," which was strongly supported by organised labour and by some individual physicians, and even more strongly opposed by organised medicine.

Before this manuscript is in print, the Wagner-Murray-Dingell Bill will be probably reintroduced into the Congress of 1945, with substantial changes. Numerous alterations are expected in the administrative provisions, which were responsible for a good deal of the criticism of the 1943 Bill. Federal aid for hospital construction, especially for rural areas, will be probably incorporated. Until now, popular attention has been mainly directed to methods of prepaying, and thus easing the burdens of medical costs. It is now turning to the fact that under any prepayment system, the quality and cost of medical care are greatly affected by the way in which professional services are organised and paid for. While medical science has become more and more efficient, it has also become more and more complex and expensive,

with the result that the gap between medical knowledge and practice has been widening. Since, with the great increase of specialisation, it is no longer possible for any one physician to possess more than a fraction of available knowledge and skill, group medical practice has become the desirable method of furnishing medical services. This systematic association of a number of physicians, with joint use of equipment and technical personnel and with centralised administration, is already well developed in many of the best hospitals and clinics of the country and among private physicians, chiefly in the Mid-West. The enlargement of group practice is now recognised as one of the needed parts of any comprehensive health programme.

The present issues in relation to the distribution of the risks of sickness and the costs of medical care, centre around the following questions. Which method of distributing costs should be employed in the future—taxation or insurance? Shall we extend the use of taxation above the very low-income or no-income groups, and/or how far shall our government (national or State government) undertake health insurance, instead of leaving it entirely to voluntary agencies, as it is being done to-day?

Tax supported medical care in America has been expanding over a period of many decades. To prevent, control, and care for specific diseases through tax supported programmes, is one of the main tasks of public health authorities, entailing general sanitation, food inspections, industrial hygiene, acute communicable diseases, tuberculosis, venereal diseases, mental diseases, maternal hygiene, school hygiene, and certain laboratory services, etc. Institutional care of patients with mental diseases, and with tuberculosis also, has long been accepted as a community responsibility. More recently, programmes of mental hygiene have been emphasised, and cancer, children's physical handicaps and dental defects have been dealt with as public programmes in some States, counties and cities.

Tax-support is also accepted for programmes designed to meet the special needs of certain population groups, exposed to health dangers due to their age, sex, occupation, or socio-economic conditions. These groups include merchant seamen, children, the needy aged and the needy blind, women in need of maternity care, the legally indigent and the medically needy. Public responsibility covers diagnostic and therapeutic measures as well as preventive services. The economic circumstances of the potential beneficiaries are often considered as a condition of eligibility for preventive services, but are generally a stipulation for curative work. Medical services for "relief" cases differ from locality to locality, and range from those places in which relief clients can obtain home care in serious emergencies only, to places in which a well-organised system makes care available to any needy person. Tax-supported hospital care has also become more widely available during the last 15 years, by the extension of government or community owned hospitals, and by the growing use of tax funds for payments to voluntary hospitals for the care of persons eligible for public medical aid. A unique programme of medical services is provided by the Farm Security Administration, to low-income farm families in need of economic and medical rehabilitation. At its peak, over 100,000 families in more than 1,000 localities received such services in a programme which set a useful pattern of co-operation with local medical societies.

During the war, public health authorities assumed new responsibilities

with regard to the growing health needs of the civilian population on the one hand, and of the armed forces on the other hand. With the shortage of civilian physicians becoming more acute than ever before, especially in rural areas, Public Health Service tried to relocate doctors at public expense, and to place public health physicians in communities where medical needs were demanding. With war-expanded communities unable to take care of their increased populations, federal funds (provided by the Lanham Act) have been used to build road, schools, sanitary and hospital facilities. With added cases of tuberculosis and venereal diseases, increased federal appropriations were made in order to deal more effectively with these diseases. With the mounting demand for manpower, a national programme of grants-in-aid to the States was created to supplement the necessary funds for the rehabilitation of disabled persons, of whom 44,000 were returned to employment in 1944. The acute farm labour shortage necessitated the increased use of migrant farm workers from Mexico, the Bahamas, etc., and the War Food Administration had to set up a medical care programme designed, partly to protect the country from the importation of tropical diseases, and partly to take care of these farm workers and their families during their stay in this country. The War Food Administration also undertook the dissemination of information concerning matters of nutrition, and thus made a larger proportion of the public, diet conscious.

Special needs of servicemen's families were recognised in 1943, in the establishment of an Emergency Maternity and Infant Care programme for the wives of enlisted personnel of the lower pay grades. By June, 1944, every State had established such a programme (for which Congress appropriated funds) to provide pre-natal care, delivery and post-natal care, as well as complete pediatric service for the infant until it is one year old. Direct payments for these services are made by the government to physicians and hospitals on behalf of the mother and the baby. The woman is free to choose her own doctor, provided he will accept her as a patient under the programme, and agree to the compensation as paid by the government. To all members of the armed forces, the Medical Corps of the Army and the Navy extended preventive and curative services, unexampled in scale and effectiveness. Extensive medical care and hospitalisation programmes went into effect to take care of the war veterans. The supply of future physicians and nurses has also become largely a federal subject, with medical education taken over almost entirely by the Army and Navy, and education of nurses mainly supported by federal funds (under the Bolton Act).

Voluntary insurance in the United States began many years ago in a number of industries, chiefly mining, lumbering, and railroading in the West. Sick benefit plans run by fraternal societies, labour unions, and mutual benefit associations also have a long history. The chief function of these voluntary plans was to give cash benefits during sickness, and only a few organised groups of private physicians began to supply medical care on a prepayment basis to organised subscribers by 1930. It was not until 1933, that voluntary health insurance began as a social movement, when the trustees of the American Hospital Association approved "the principle of hospital insurance as a probable solution of the distribution of the costs of hospital care." To-day, according to a recently published study, there are more than 200 voluntary prepayment plans in operation, covering about 21 million persons. About 17 million of these belong to plans supplying



hospital services only, and 3.6 million to programmes providing physicians' services on a prepayment basis. These voluntary health insurance plans are either approved or sponsored by professional bodies, such as hospital groups or medical societies, by consumer groups, by industry, or by commercial insurance companies. A few labour unions have set up plans of their own, and recently begun to provide health protection for their members, by bringing industrial health and general medical care into the arena of collective bargaining. In a few rural communities, local "farmers' health associations" have set up their own insurance plans, in some instances aided by government subsidies.

The prepayment organisations vary greatly in the scope, combination of services, and in the different limitations placed on the amount of care furnished, or on persons and diseases covered.

All the existing voluntary plans have succeeded in reaching not more than one sixth of the population as yet, and in giving them only incomplete care. Experience in other countries proves, that only a compulsory plan can assure to a whole population the comprehensive medical services needed to cure and prevent sickness, and to protect and improve the health of the individual and of the nation.

Any survey of medical care in the United States brings out a final important fact. Public and professional interest in the subject, which grew during a period of many years, has increased recently still more rapidly. Long time influences arising from medical science and technology, and from economic and social changes, have resulted in a change in social philosophy. New concepts have emerged, namely, that the health of the people is a public concern, and that medical care in its widest sense, is an essential human right to be guaranteed and safeguarded in any programme against insecurity. Since leading figures in all political parties have recently affirmed this right, confidence in the realisation of comprehensive medical care for all the American people seems justified.

## Food and Health Problems in Australia

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FOR more than 50 years Australia has exported large quantities of foodstuffs such as wheat, dairy produce, meat and fruit. A large proportion of these products was sent to the United Kingdom. In fact, in 1937 Australia supplied roughly one sixth of the meat, butter and apples imported into the United Kingdom. While the war has altered the structure of this trade, it is a fact that large quantities of foodstuffs have continued to arrive from Australia. However, it may not be generally appreciated that, during the war, Australia has also supplied very large quantities of foodstuffs to the armed forces of the Allies in the Pacific area. About the middle of last year

Mr. Curtin stated that Australia, with a population of about seven million people and with only about one seventh of her manpower engaged in primary production, is producing enough food to support about 12 million people. He added that about nine-tenths of the food needed by American forces in the South West Pacific Area was being supplied (under Reciprocal Lend-Lease) by Australia.

These facts should be sufficient to show that the problem of feeding the civilian population in Australia is likely to be very different in many respects, from the problem of feeding the civilian population in Britain.

On various occasions it has been shown that, together with a few European countries such as Holland, Denmark and Switzerland, New Zealand and Australia enjoy the highest standards of living and the best standards of health in the world.\*

It is by no means true, however, that all people in Australia are well fed and that nutritional problems do not exist. Considering the important part which Australia played in having attention focussed on the problem of food and health at the League of Nations, it was quite appropriate that the Commonwealth Government should set up, in 1936, an Advisory Council on Nutrition. The duties of this Advisory Council were to study and report on the state of nutrition of the Australian people, and to determine whether there were any signs of under-nourishment or of improper balance of diets.

The Council has issued six reports, and special attention should be drawn to the fifth report,† which contains a comprehensive statement of the analyses of Australian food, and to the final report,‡ which considers the information collected as the result of dietary and clinical surveys and makes certain recommendations as a result of their findings. In addition, the Nutrition Committee of the National Health and Medical Research Council (which Committee was set up on the recommendations of the Advisory Council on Nutrition) has, since its inception, issued three annual reports. Before considering some of the findings of the Council and the Committee, it is advisable to give a little information about the distribution of food production in Australia, and of the distribution of population in relation to the food producing areas.

Although Australia is a vast continent with an area of over 1,900 million acres, one only needs to look at any reliable map of the average annual rainfall to see that a great part of the interior of the continent has a rainfall of less than ten inches per year.§ This area—which occupies part of Western Queensland and New South Wales, and stretches through large areas of South Australia to the Southern coast and through a large proportion of Western Australia—cannot be used for the production of crops and supports a very small proportion of the total population of sheep and of cattle. The remainder of the continent can be divided into fairly definite regions according to the annual rainfall, and this division provides a key to the distribution of production of the various kinds of foodstuffs.

\* See *Final Report of the Mixed Committee of the League of Nations on the Relation of Nutrition to Health, Agriculture and Economic Policy*, also *Statistics of Food Production, Consumption and Prices*.

† *Fifth Report of the Advisory Council on Nutrition*, 1938.

‡ *Final Report of the Advisory Council on Nutrition*, 1938.

§ *Land Utilisation in Australia* (Wadham and Wood).

Firstly, there is a rather narrow coastal belt, stretching from Southern Queensland through New South Wales and Victoria, having soil of high fertility and a rainfall of 30 inches to 60 inches per year. Similar conditions are found in limited parts of the coastal areas of South Australia and Western Australia, and also in a considerable proportion of the agricultural areas of Tasmania. It is in this coastal belt that most of the dairying is concentrated, and that crops such as potatoes and vegetables are produced. Beef cattle are also raised within this dairying area and, of course, there is a considerable production of beef and veal as a by-product of the dairying industry. The main areas of beef production are, however, in Northern Australia where the rainfall is 20 inches or higher. This area forms a wide belt (200-300 miles in places) stretching up the coast of northern New South Wales and Queensland, and then as a discontinuous belt through the Northern Territory into the north-east of Western Australia.

Most of the wheat is produced in an area where the rainfall is between ten inches-20 inches, and this area forms a belt bordering on the inland side of the dairying belt. It is in the area where these two belts (dairying and wheat) meet and overlap that most of the fat lamb is produced. Sheep are also distributed throughout the wheat belt and, since their requirements for water are smaller than those for cattle, sheep in great numbers are also found in the drier areas of New South Wales, Queensland, South Australia and Western Australia. For the most part, however, these sheep are used for the production of wool and do not make an important contribution to food production.

In this survey of food production rather more than a half of the total area of the Australian continent has been considered. It must be remembered however, that a balanced diet can only be maintained when the diet includes such items as milk, eggs, green vegetables and fresh fruit, and these are the very products which can only be produced in large quantities in the restricted areas of higher and reliable rainfall. It follows therefore, that the problem of nutrition in Australia may not be confined to the industrial areas of the larger towns and cities, most of which happen to be situated within the higher rainfall area. Indeed there are two further sections of the population which need special attention.

1. Inland mining areas such as Broken Hill and Mount Isa which are far removed from the areas where milk, eggs and green vegetables are produced.
2. Scattered communities ranging in size from individual homes to small railway towns, especially those in the lower rainfall areas where sheep, cattle or wheat are produced.

The Advisory Council of Nutrition has collected information from the capital cities and from inland country districts, and this information refers both to food consumption and also to the nutritional status of some of the children in these areas. The food consumption surveys were organised with the help of infant welfare centres, kindergartens and church organisations. A special medical officer, equipped with a small portable laboratory and x-ray unit, undertook the clinical work on children.

Some of the main results obtained as the result of surveys in the capital

cities of Brisbane, Sydney, Melbourne, Adelaide and Perth can be stated as follows :

1. About 1/20th of the diets surveyed were below normal requirements as regards calories and proteins, and were judged to be inadequate or undesirable for proper nutrition.
2. About  $\frac{1}{4}$  of the diets contained 0.6 pints of milk per day or less, and it is considered that this proportion of the surveyed population is receiving less milk than the minimum amount necessary for adequate nutrition.
3. About  $\frac{1}{4}$  of the diets contained less eggs and potatoes than the quantities recommended by Stiebeling and Ward.
4. In small families of one, two and sometimes three children, the consumption of protective foods reaches a satisfactory standard, but in larger families, the consumption is below the selected standards.
5. An outstanding result was the high percentage (up to 75 per cent.) of the diets which failed to contain the selected standards (Stiebeling and Ward) for calcium, phosphate and iron.

As a result of the special study of the nutrition of children in the Metropolitan Area of Sydney and in inland areas of four of the States, the following conclusions were reached :

- (a) Upwards of 20 per cent. of the children in some areas were suffering from unsatisfactory nutrition.
- (b) Mild rickets was found in eight to ten per cent. of the children examined and, in some smaller towns, active rickets was found in about six per cent. of the children examined.\*
- (c) Numbers of infants either could not or did not obtain certain foods such as vegetables, fruit and milk which are rich in minerals.
- (d) The diets of rachitic infants were usually deficient in fat with excess of carbohydrate. This form of diet is usually associated with a deficiency of fat, soluble vitamin A, and a partial or complete deficiency of vitamin D. Moreover, there is usually a disturbance of the Ca : P ratio with low calcium supply or even an absolute deficiency of calcium.

**Recommendations of the Council :** While it was emphasised that the degrees of ill-health discovered as a result of the survey were of a minor character, the Council considered that the position was serious enough to cause real concern to the authorities in Australia. To meet the situation several recommendations were made :

1. That the Commonwealth Department of Health should form a division for the study of child growth, with special reference to child diet.
2. That plans should be made for the extension, under medical supervision, of kindergartens, nursery schools and similar movements.
3. That there should be co-operation with State Departments of Health and Education in schemes for general education in diet and food hygiene.

The Council also drew attention to the following points :

- (a) The need for specially trained medical people to undertake the proposed work on child growth and diet.

\*In a more detailed study F. W. Clements, who was in charge of these investigations, reported that there was evidence that about 50 per cent. of infants in some Australian communities developed mild rickets at some time during the first year of life. (*See Med. Jour. Aust.*, 21st March, 1942, page 336.)

- (b) The value of skimmed milk as a food and the urgent need for education in this matter.
- (c) The need for arrangements whereby all country towns would have a plentiful supply of fresh milk, milk products, cheese, fruit, vegetables and fish, preserved under conditions of refrigerated transport and storage.

**Some Special Factors in Nutrition in Australia :** The work of the Advisory Council, and more recently of the Nutrition Committee, has drawn attention to some further points of special interest in Australian diets :

1. Australia as a whole, by virtue of climate, etc., does not produce an abundance of foods rich in vitamin C. Citrus fruits and tomatoes are very important sources of vitamin C, but these products are often unavailable in inland areas. Potatoes are also a very important source of vitamin C. In fact, in some inland areas of Queensland and New South Wales in times of peace, potatoes have provided the main source of this vitamin. Since potatoes cannot be produced in many of these areas, and since, under war conditions, there has been a shortage of supplies and of transport, the consumption of potatoes has dropped much below the normal. Indeed, the situation over wide areas of Australia is such, that the Nutrition Committee has recommended that a comprehensive plan should be developed for distributing synthetic ascorbic acid tablets to infants and children in these areas.
2. In 1941, the Nutrition Committee surveyed the position concerning the supply of vitamin B1 in the usual Australian diet. It was found that Australian wheat is rich in this vitamin, since the whole berry contains, on an average 760 I.U. per lb., while average white flour contained 235-270 I.U. per lb. (or about  $\frac{3}{5}$  of the B.1 content of British National flour of 85 per cent. extraction). White bread was found to contribute about  $\frac{1}{4}$  of the total intake of vitamin B.1 and, while there was evidence that there was some moderate deficiency of this vitamin in some individuals, it was evident that this was usually due to the fact that the diets as a whole contained a high proportion of foods having little or no vitamin B.1. Since there were considerable difficulties in the way of raising the extraction rate of the flour, the Committee was not able to recommend the raising of the extraction rate as a means for raising the vitamin B.1 content of the average Australian diet.

### **Future Problems**

So far we have been concerned with food production, diets and health in Australia under present day conditions. It has been shown that Australia with a population of seven million people produces enough food to support a total of about 12 million people. Can it be deduced from the facts already given, that Australia could greatly increase her population and still supply sufficient food to feed them? The answer to such a question can only be attempted after a careful study of land utilisation in Australia. Some authoritative comments in connection with this subject are given in recent

publications of the Commonwealth Rural Reconstruction Commission.\*†

These publications show the position very clearly, for it is stated that of the total area of 1,903 million acres, only 183 million acres have a rainfall suitable to dairying and the production of crops such as fruit, vegetables and potatoes. Of the rest, 281 million acres occur within areas of low to medium rainfall where seasonal crops (wheat) may be produced, and the remaining 1,439 million acres lie in regions where the rainfall is low and often uncertain. This statement alone should show that the areas of high fertility and high rainfall are much more restricted than most people realise. Soil fertility is a matter of very real importance, and it has been emphasised that in Australia, where agriculture is of recent origin, it has not yet become the practice to pay sufficient attention to the maintenance of soil fertility. In fact, some farming practices have led to a steady lowering of fertility and consequently of returns, and, in some areas, it is still the practice to exploit the land for a short time and, when returns are unsatisfactory to abandon it.

Soil erosion is another serious problem, and some of the devastating effects of wind erosion have recently been described in the British press. These articles have described the more spectacular aspects of soil erosion; nevertheless, a balanced survey of the position, such as that given in the publications of the Rural Reconstruction Commission,‡ leaves no doubt that soil erosion is a very real problem in Australia. In the high rainfall coastal areas, where dairying is the main primary industry, the problem is a local one and shows up in the form of gullying and some sheet erosion. These forms of erosion are more serious in some lower rainfall areas, especially in the good wheat lands of New South Wales and Queensland. It is in the extensive drier parts of the continent where the worst wind erosion occurs, and careful investigation has shown†§, that, in many cases, this trouble has followed the serious overgrazing of the land. This overgrazing destroys much of the natural vegetation and wind erosion follows.

The extension of irrigation in some areas is sure to be an important factor in increasing the productivity of the land and, to a certain extent, of providing some insurance against the effect of the droughts which occur at intervals. Even here, however, there are limits to the expansion and, in the long run, these limits will be determined by the supply of water available. The Rural Reconstruction Commission sums up the position by saying: "Australian agriculture will in time need all the water it is possible to conserve." Of the future of agriculture in general the Commission says: "The key problem is that of devising and adopting systems of agriculture which will maintain soil fertility and permit stable methods of farming in the better rainfall zones, and in the larger part of our farm lands on soils which are not naturally very fertile."

**Conclusion:** Australia is a country where great differences exist in the conditions under which primary production is carried on. To appreciate this fact it is only necessary to contrast the sheep raising areas on the dry saltbush country, with the tropical coastal areas where luxurious rain-

\**A General Rural Survey by The Rural Reconstruction Commission, 1944.*

†*Land Utilisation and Settlement by The Rural Reconstruction Commission, 1944.*

‡*Soil Drift in the Arid Pastoral Area of South Australia, by F. N. Ratcliffe, C.C.S.I.R. Pamphlet No. 64.*

§*Further Observations on Soil Erosion and Land Drift with Special Reference to South-Western Queensland, by F. N. Ratcliffe, C.C.S.I.R. Pamphlet No. 70.*

forests occur and tropical fruits are produced in abundance. Or one might contrast the way of life on the large inland wheat stations with that in the rich pasture areas of the coastal belt where the dairying industry is so highly organised.

It is impossible in a statement of this kind to describe adequately the problems of health and food production in a country where such great differences exist.

The problem of providing conditions so that all the people are properly nourished is in itself rather formidable, as the recommendations of the Advisory Council of Nutrition plainly show. The problems of achieving a proper balance of agriculture, in which sheep and cattle are properly fed and good crops are produced without loss of soil and of soil fertility, are very much greater.

It can be said, however, that Australia will continue to be an important producer of food but, if her own people are to be properly nourished and the exports of food maintained, then very careful planning of all aspects of Australia's agriculture and forestry will be needed.

## Health and Social Welfare in New Zealand

LORNA C. M. MCPHEE, B.A., Librarian, New Zealand Government Office.

NEW Zealand is a comparatively young country. It is just one hundred and five years since organised settlement began with the arrival of the first British colonists in Wellington in 1840. During this short history however, enormous progress has been made—a fertile wilderness has been converted by a small but energetic population into a prosperous modern state, which has achieved in very great measure the democratic ideal of a community with an economic organisation adapted to social needs, and in which social justice is the guiding principle of administration. It has been said that "New Zealand is an experiment in the eighteenth century idea of the rights of man, carried out with moderation and compromise." A study of the great body of social and industrial legislation enacted by successive New Zealand Parliaments upholds this claim.

The welfare of the common man is acknowledged as the supreme object of governmental policy, and the fact that New Zealand has developed as a country without extremes of great poverty or great wealth has not happened by accident. The present population is small but homogeneous. The most recent census held in 1936 records the fact that 95 per cent. of the population (excluding the Maori population numbering less than 100,000) are of British origin; 80 per cent. of the European population are New Zealand born, and 19 per cent. born in other British countries. Only one per cent. are of foreign origin. The total population is approximately 1,650,000 and in area the Dominion is about the same size as Great Britain and Northern Ireland. This population is fairly evenly distributed between town and country, and of those in employment 79.4 per cent. represent

wage and salary earners, 9·1 per cent. are employers of labour, and 11·5 per cent. are engaged in industry on their own account. Further, a free and compulsory education system inaugurated over 60 years ago has ensured the literacy of the people, and all these factors taken together have created an environment ideal for the working of representative institutions, and where, in contrast to older and larger communities, no immeasurable gulf has been created between the Government and the governed.

Progress towards social equality has been made under pressure of public opinion and a tradition of state activity has been woven into the pattern of economic and social organisation in New Zealand. The Industrial conciliation and Arbitration legislation, the Mining legislation, the Shipping and Seamen legislation, the Housing legislation and the Fair Rents Acts, the Factories Act, the Shops and Offices Act, the Agricultural Workers' Act, the Wages Protection and Contractors' Liens Act, the Workers' Compensation Act, the Annual Holidays Act, the Prevention of Profiteering Act—all these and many other enactments of Conservative, Liberal and Labour Governments in New Zealand have been designed to achieve a fair distribution of the rewards of industry between employers and employed, and to establish minimum standards of working and living conditions.

Within the framework of the Social Security legislation passed in 1938, and steadily amended in the intervening years between 1938 and 1945, New Zealand has built up a system of health and social services which, in scope and liberality, is probably without parallel in the world to-day. Social security in New Zealand has passed beyond the stage of planning: it is a factor in the daily life of the whole community. Furthermore, it has come to stay. It has been said that "for any future Ministry to abolish the scheme would be its political *hara-kiri*," and the truth of this statement is borne out by the endorsement given to social security by the official opposition in New Zealand on the occasion of the most recent General Election in 1943. Changes may be made in the future but the essence of the scheme will remain—it has taken root in the country's economy. The legislation "aims to provide for the payment of superannuation benefits designed to safeguard the people of New Zealand from disabilities arising from age, sickness, widowhood, orphanhood, unemployment, or other exceptional conditions; to provide a system whereby medical and hospital treatment will be made available to persons requiring such treatment; and, further, to provide such other benefits as may be necessary to maintain and promote the health and general welfare of the community."

The Social Security legislation is a consolidation and extension of previous measures passed to protect the New Zealand citizen from want. The first old age pensions legislation (granting pensions of £18 per annum) to be enacted in a British country was passed by a Liberal Labour Government in 1898; a tiny pension was given to widows in 1911, and to the blind in 1924. A modest beginning in the grant of family allowances was made when the Family Allowances Act was passed in 1926. Under this Act a family whose income was less than £4 a week became entitled to two shillings a week for every child after the second—a sum described by a Labour Party spokesman of the day as insufficient to maintain a respectable fowl, much less the third child of a family in the lowest income group. Unemployment insurance commenced in 1931, and invalidity pensions in 1936. With the



exception of the unemployment benefit all these earlier monetary benefits were on a non-contributory basis.

The Social Security Act 1938, placed the whole system of benefits on a contributory basis. Every New Zealander over the age of 16 is required to register for social security, and an annual registration fee of £1 for men over 20, and 5s. for women and youths aged 16–20, is charged. All wages, salaries, and other income are subject to a deduction of a Social Security tax of 1s. in the £1, and this applies also to company incomes. Employers deduct this 5 per cent. tax at the source when salaries and wages are paid out. All other incomes and earnings must be declared annually to the Land and Income Tax Department at the same time as the income tax returns are submitted. The proceeds of both tax and fees are paid to the social security fund within the public account, and the system of tax collection by the Land and Income Tax Department has the merit of great administrative simplicity and low administrative cost in relation to the sums involved. The fund is supplemented annually by grants from the Exchequer out of revenue from other sources. These grants amount to something less than one quarter of the total annual receipts in the fund.

**Table No. 1.—Social Security Fund Revenue.  
Year Ended 31st March 1944.**

	£	£
Registration fees .. .. .	551,064	
Charge on wages and other income .. ..	12,796,108	
Penalties, fines, interest and miscellaneous ..	44,912	
	<hr/>	13,392,084
Grants from Consolidated Fund, vote " Social Security " .. .. .		4,100,000
Balance from previous year's operations .. ..		3,086,801
		<hr/>
		£20,578,885

*Note.*—Revenue for previous years since the coming into force of the Social Security Act :

1939–40	1940–41	1941–42	1942–43
£	£	£	£
11,367,118	13,967,823	14,687,682	16,013,641

Opponents of the scheme have argued that New Zealand cannot afford social security, but there has been no difficulty in raising the sums involved during the last five and a half years of war, when the country's finances were heavily committed to the urgent necessities of defence expenditure. The sums spent on making the life of the New Zealand citizen moderately comfortable are infinitesimal compared with those spent on defending his life : the revenue collected for the War Expenses Account for the prosecution of the war amounted in 1943–44 to £162,540,454 as compared with £20,578,885 in the Social Security Fund.

The method of financing social security in New Zealand is on an entirely different basis from that proposed in the British White Paper on social insurance. In New Zealand the amount of tax paid by each individual bears a fixed relation to what he received in the way of salary, wages or unearned income. In Britain the contribution is an insurance premium

related, not to income, but to the different security needs of the various classes of contributors. Since only the health and superannuation benefits are universal, all others—with the exception of the miners' benefits—being subject to a generous "means test," it is inevitable that in New Zealand those who contribute most, actually receive the least in cash return, and the whole scheme has the effect of redistributing the national income.

**Table No. 2.—Social Security Fund Expenditure.  
Year Ended 31st March 1944.**

MONETARY BENEFITS :					£	£
Universal superannuation	..	..	..	..	778,758	
Age	..	..	..	..	8,101,668	
Widows	..	..	..	..	949,099	
Orphans	..	..	..	..	22,442	
Family	..	..	..	..	876,858	
Invalids	..	..	..	..	1,067,409	
Miners	..	..	..	..	76,652	
Maori War	..	..	..	..	119	
Unemployment	..	..	..	..	32,316	
Sickness	..	..	..	..	376,878	
Emergency	..	..	..	..	115,574	
						12,397,773
MEDICAL BENEFITS :						
Medical benefits	..	..	..	..	1,179,331	
Hospital benefits	..	..	..	..	2,133,389	
Maternity benefits	..	..	..	..	513,939	
Pharmaceutical benefits	..	..	..	..	762,198	
Supplementary benefits	..	..	..	..	137,823	
						4,726,680
ADMINISTRATION EXPENSES :						
Land and Income Tax Dept.	..	..	..	..	120,000	
Health Department	..	..	..	..	80,000	
Social Security Dept.	..	..	..	..	309,293	
						509,293
Balance	..	..	..	..	..	2,945,139
						<u>£20,578,885</u>

**Table No. 3.—Benefits and Pensions in Force 1943-44.**

					£
Universal superannuation	..	..	..	..	49,289
Age	..	..	..	..	102,530
Widows	..	..	..	..	10,836
Orphans	..	..	..	..	412
Family	..	..	..	..	15,950
Invalids	..	..	..	..	12,126
Miners	..	..	..	..	795
Maori war	..	..	..	..	1
Unemployment	..	..	..	..	292
Sickness	..	..	..	..	4,446
Emergency	..	..	..	..	1,915

Social security in New Zealand can be conveniently considered under two headings :

- (a) Monetary benefits.
- (b) Health benefits.

### **Monetary Benefits.**

The monetary benefits paid under the provisions of the Act and its amendments insure the citizen against financial loss resulting from old age, illness, invalidity, orphanhood, widowhood, unemployment, and similar natural disasters. Workmen's compensation has not been consolidated into the social security system but is included in the labour code. Funeral benefits and marriage grants which were included in the Beveridge plan do not appear in the New Zealand scheme but as the Prime Minister, the Right Honourable Peter Fraser has said, under social security in the Dominion "every citizen has an acknowledged *right* to . . . adequate food, clothing and shelter, to medical care and provision for his old age . . . he has a *right* to social security." With the exception of the universal superannuation payments, all cash benefits came into force on the 1st April, 1939. The rates now being paid, and which are quoted in the following paragraphs, have been increased by varying amounts since the original payments were made in April, 1939.

### **Universal Superannuation.**

Superannuation payments are paid to all citizens aged sixty-five or over *without means test*, subject to the fulfilment of residential qualifications (*viz.* continuous residence for ten years prior to the 15th March, 1938, for those in New Zealand on that date, and twenty years' continuous residence if not in New Zealand on that date—allowances are made for temporary absence). Payments were commenced at the rate of £10 per annum in the first administrative year, 1940–41, and are increased annually by £2 10s. until the maximum—£84 10s., or 32s. 6d. is reached. The rate payable on the 1st April 1945, was £22 10s. per annum.

### **Age Benefits.**

Age benefits at the rate of £1 12s. 6d. are payable at 60 and are subject to the same residential qualifications as for universal superannuation. Payments are, however, subject to a "means test," but this concept is generously interpreted in the Dominion, no account being taken of the applicant's home or furniture, or of any interest in land or mortgages on land, or the value on any interest in any annuity, or in any unmaturing life insurance policy. In addition there is a further property allowance of £500 before the basic rate of benefit is affected, after which the benefit is reduced by £1 per annum for every complete £1 of annual income in excess of £52 per annum and for every complete £10 of net property. Where the beneficiaries have dependent children under 16 the Commissioner has power to grant increases at the rate of £27 6s. for each child, with a maximum benefit of £260 per annum.

### **Widows' Benefits.**

Widows' benefits are payable at the rate of £1 5s. per week to childless widows over fifty, subject to qualifications concerning residence and the duration of marriage.

Widows, with children under sixteen, who fulfil the requisite residential qualifications are entitled to £1 10s. a week plus 10s. 6d. a week for each child up to a limit of £5 a week. Widows' benefits are reduced £ for £ in respect of other income in excess of £52 per annum in the case of childless widows, and £78 per annum in the case of widows with dependent children under sixteen.

### **Orphans' Benefits.**

Orphans under sixteen who were either born in New Zealand or whose last surviving parent lived in New Zealand for three years immediately preceding death, are entitled to a benefit in cash up to 15s. 9d. per week.

### **Family Benefits.**

This important contribution to the security of the family is paid at the rate of 10s. for each child, but may be reduced by 1s. for every 1s. a week by which the family income, excluding the benefit, exceeds £5 10s. a week. The family benefit is paid to the mother, and an essential condition to the granting of the family benefits is that the amount received must be spent on the maintenance or education of the children concerned.

### **Invalids' Benefits.**

These payments are made in cases of permanent incapacity for work and total blindness. The basic rate is £1 12s. 6d. a week, plus 10s. 6d. a week for the wife and for each child. A married woman totally incapacitated receives £1 12s. 6d., and an unmarried invalid under twenty-one receives £1 2s. 6d. The payment of invalids' benefits is subject to income and residential qualifications. An interesting and humanitarian feature of this type of benefit is the special provision which has been made for blind persons. Personal earnings up to £3 per week do not affect that payment of the full basic rate and, in addition, actual earnings are subsidised by 25 per cent. so long as the total income, including earnings and subsidy benefit do not exceed £240 10s. per annum or £4 12s. 6d. per week.

### **Miners' Benefits.**

This class of benefit is available to any miner seriously and permanently incapacitated for work as a result of miners' phthisis, or totally and permanently incapacitated as a result of other occupational disease associated with mining, provided that he has been working as a miner at least two and a half years, and has lived in New Zealand for at least five years. Rate of benefit is £1 12s. 6d. per week, plus 10s. 6d. for wife and each dependent child under sixteen, with a maximum of £260 per annum.

### **Sickness Benefits.**

Temporary loss of earnings through sickness are provided for by the payment of sickness benefit at the rate of £1 per week, and 15s. for a wife and 10s. 6d. for each dependent child. Workers between 16 and 20 without dependants receive 10s. 6d. per week. Every person over 16 who has resided in New Zealand for a year is entitled to this benefit.

The benefit is not usually payable for the first seven days of incapacity,

but payment is continued for as long as the incapacity lasts, or until the beneficiary qualifies for some other benefit.

### Unemployment Benefits.

The unemployment benefit is payable to every unemployed person over 16, resident in New Zealand for one year, who is capable of work, is willing to undertake suitable work, and who has taken reasonable steps to obtain employment. Rates on a scale identical with those paid for loss of earnings through sickness are paid, and the maximum benefit payable in any one case is £4 per week.

### Maori War Benefits.

Benefits in this class are granted to every person who served in any of the Maori Wars of the 19th century and received an award for active service. On the 31st March, 1944, only one benefit of this class remained in force. The rate paid is £1 12s. 6d., and payment is made without means test.

*NOTE.—Provided that children be beneficiaries under the various classes of benefits remain at school and the money is spent for this purpose, payments may be continued until the children reach eighteen years of age.*

### Emergency Benefits.

An entirely new principle is introduced into New Zealand social legislation by the payment of this type of benefit. This provision enables financial assistance to be granted by the Commission to people who are in need of help, but who for some reason beyond their control are unable to qualify for any of the benefits summarised above. The amount paid is at the discretion of the Commission, but is usually as nearly as possible equal to the amount paid for the type of benefit for which the applicant most nearly qualifies.

The introduction of the various benefits just described involved no major difficulties since the legislation and its enforcement was a problem of administration only. The introduction of the health benefits has presented difficulties which, though capable of solution, have not yet been settled to the satisfaction of either the Government or the medical profession.

### Health Benefits.

Although a pioneer in many types of social legislation, it was not until 1938, with the passing of the Social Security Act, that New Zealand introduced a national health insurance scheme comparable with those operating in many other countries.

The principle of universality which operates in the payment of superannuation also applies to the grant of medical benefits under social security. Every person ordinarily resident in New Zealand is entitled to these benefits. The scheme is a comprehensive one and the various classes of benefit have been put into force as soon as machinery and resources permitted. The several classes of benefits, with dates of inauguration, are as follows:

- (1) Free treatment in State mental hospitals. 1st April, 1939.
- (2) Maternity benefits. 15th May, 1939.
- (3) Hospital benefits (in-patient treatment). 1st July, 1939.
- (4) Hospital benefits (out-patient treatment). 1st March, 1941.

- (5) General practitioner services under capitation scheme. 1st March, 1941.
- (6) Pharmaceutical benefits. 5th May, 1941.
- (7) Benefits in respect of general medical services as an alternative to the capitation scheme. 1st November, 1941.
- (8) X-Ray diagnostic services. 11th August, 1941.
- (9) Massage benefits. 1st September, 1942.
- (10) District nursing services. 5th July, 1944.

The introduction of free maintenance in State Mental Hospitals was a simple matter. Responsibility for cost was transferred from the relatives to the Social Security Fund, and only in one small hospital is any charge now made for treatment of mental patients. The cost to the Fund during 1939-40 was £166,000, and in 1942-43, £181,869.

Maternity benefits imply free medical treatment for the expectant mother, free medical attention during confinement, and either free hospital treatment or the services of a maternity nurse in the home. Only six practitioners and two hospitals (out of a total of 202) in the Dominion have refused their services in the operation of the Maternity Benefits Scheme. The doctors and nurses performing these services are paid on a fixed scale of fees from the Social Security Fund, while the hospitals receive a grant in aid from the Fund. The original Maternity Benefits scheme under which the doctors were required to perform maternity services under a form of contract with the Minister of Health was unacceptable to the profession, but the scheme now in operation is eminently satisfactory and has the goodwill and co-operation of all concerned. Payments from the Fund for this purpose amounted to £283,813 in the year 1939-40, and have increased to £513,939 for the year ended 31st March, 1944.

Treatment in the four types of hospitals which exist in the Dominion is afforded by Hospital Benefits under the Social Security Act. Free hospital treatment is available in the Public Hospitals (controlled by elected Boards) and in semi-public hospitals such as the Karitane Baby Hospitals run by the Plunket Society. Hospital fees in licensed private hospitals and in the two special Government convalescent hospitals at Rotorua and Hanmer, are reduced by the payment from the Social Security Fund of 9s. per patient per diem. In addition to these payments in respect of individual patients, public hospitals are subsidised from general taxation on a £ for £ basis. The fees which private hospitals are permitted to charge are subject to approval by the Minister of Health.

With very few exceptions out-patient services by Public Hospitals are free to the patient, payment being made from the Social Security Fund at the rate of 60 per cent. of the actual expenditure incurred by the Boards on salaries and materials for these services.

Health services under social security stand or fall by the efficiency of the general practitioner services. Heated controversy, which has not yet entirely died down, has centred around the introduction of this part of the scheme. Neither the Government nor the profession is completely satisfied that the best solution has yet been found, but so far as the public is concerned the fear of running into debt through consulting doctors in times of ill-health has been obviated, and the personal relationship between doctor and patient, to which the greatest importance is attached, has been preserved. At the present time two systems for the payment of doctors operate concur-

rently, and in all there are four types of organisation of social security medical services: The capitation scheme (1.3.41); the "fee for service" scheme (1.11.41); services in special areas, and arrangements with Friendly Societies.

Under the capitation scheme, doctors contract to provide non-specialist services to all patients on their panel for an annual fee of 15s. per patient. Mileage is paid at the rate of 2s. per annum for every mile over three that the patient lives from the doctor's surgery or residence, but has no application to patients living in the same borough. The merit of this scheme is that under it the doctor's income is determined by the number of patients on his list, and not by the amount of visiting he does, and it is therefore in his interest to promote the general health of the patient, and minimise the number of separate visits.

Only a very small number of the medical practitioners registered in New Zealand were willing to operate this scheme, and the "fee for service" scheme was introduced on the 1st November in the same year and this has proved more acceptable to the profession. Doctors are paid 7s. 6d. for an ordinary consultation or visit, and 12s. 6d. for attention provided between the hours of 9 p.m. and 7 a.m., or at any time on Sunday. Additional mileage payments are also made for service outside the borough in which the doctor resides. Doctors may accept payments in addition to the fees provided from the fund, but the amount recoverable by legal action is limited to the social security rate. Many doctors consider that the charge of a small additional fee over and above the rate provided for from the fund, will protect them from unnecessary demands on their time. But the system of "fee for service" is also open to abuse from the professional point of view, as the unscrupulous practitioner can multiply the number of visits in any case of illness and still receive remuneration from the fund. These are aspects which will receive due attention if, after the end of the war in the Pacific, some alternative measure is adopted. Up to the present time no serious abuses have developed, and in spite of the absence on war service of large numbers of New Zealand doctors, medical services in New Zealand have maintained a high standard over the past four years.

The Minister of Health is empowered by the Social Security Act to make special arrangements for the provision of health benefits in areas where the two schemes above mentioned would not prove satisfactory.

Doctors are appointed on a salaried basis in special areas under this authority. Most of these are rural districts with scattered populations. In some cases the medical practitioner is appointed by the local hospital board to give medical care to all the people in the area. Funds for this purpose are granted to the Board under authority of the Social Security Act. In other cases doctors are appointed by the Health Department at salaries agreed between them and the Department. This is the most simple service to administer, as no formalities are required of either the doctor or the patient. The service is completely free.

The fourth type of general practitioner service available under social security has resulted from negotiations between the Health Department and the Friendly Societies. Some Lodges and Medical Associations had schemes in force for the provision of cheap or free medical attention before the inauguration of medical benefits under the Social Security Act. Where the range of medical service is substantially the same as that available under the main scheme, these have been encouraged to continue. The Society is

paid at the rate per head agreed upon with the Department, but in no case is a higher rate paid than that allowed<sup>1</sup> under the capitation scheme *viz.* 15s. per annum. Payments are made on the basis of regular returns of members and dependants made by the Society to the Department.

It is fitting that mention should be made here of the work of the Royal New Zealand Society for the Health of Women and Children, more commonly known as the Plunket Society. The Society was founded by Sir Truby King in 1907 "to help the mothers and save the babies," and largely through its work New Zealand's infant mortality rate is the lowest in the world. New low records have been established since the war in spite of the increase in the birth rate. The figures for the years 1940-42 are set out hereunder:

**Table No. 4.—Infant Mortality Rates  
per 1,000 Live Births.**

			<i>Males</i>	<i>Females</i>	<i>Totals</i>
1940	..	..	34.07	26.14	30.21
1941	..	..	32.55	26.85	29.77
1942	..	..	34.05	23.08	28.71

The main function of the Plunket Society is an educational one, and the field for extension of its usefulness is almost unlimited. Its work is chiefly carried out by trained Plunket nurses, but committees composed of parents who have benefited by the Plunket teaching and those interested in public health generally, are active in the educational field. Nearly three quarters of the children born in New Zealand are Plunket babies. There are 69 branches and 700 sub-branches of the society throughout the Dominion, with 137 district Plunket Nurses employed.

A simple code of rules for the bringing up of young children is taught to young mothers by unceasing propaganda. The nation-wide system of trained nurses gives sound and reliable instruction, advice and assistance, free to any member of the community desiring their help. Maternity hospitals, clinics, and special "rest homes" are maintained by the Society, which is supported by State subsidy, private subscriptions, and fees from those able to pay. Above all the Society is aided in its work by the enthusiasm of thousands of New Zealand citizens who gladly give their services in a voluntary capacity wherever they are needed.

From the care of the Plunket Society, New Zealand children pass on to another voluntary body—the Free Kindergarten Association—supported by voluntary contribution and State subsidy. Free kindergartens do not exist in sufficient numbers, however, to care for all New Zealand's 3-5 year olds, and the large majority are still cared for in the home. There are only 41 free kindergartens in the Dominion with places for about 2,000 children. From the age of five the child enters the infant department of a state primary school and passes on to the primary department at about the age of seven. He remains at the state school, in New Zealand known as the "public school," until the age of twelve to fourteen, and then proceeds to a secondary school where he may remain free of charge until 19, but must remain until the compulsory school attending age of 15 is reached. Over seventy per cent. of New Zealand's school children spend at least one or two years in full-time secondary schooling, and this number is increasing. The figure of seventy





**Sickness Benefits.**

Sick persons sixteen to twenty : without dependants	..	0	10	6
Others over sixteen	.. .. .	1	0	0
Wife	.. .. .	0	15	0
Each child	.. .. .	0	10	6

**Unemployment Benefits.**

Unemployed persons sixteen to twenty : without dependants	0	10	6
Others over sixteen	1	0	0
Wife	0	15	0
Each child	0	10	6

**Maori War Benefits.** .. .. . 1 12 6

**Emergency Benefits.** .. .. . According to circumstances.

# Public Health and Social Welfare in the Union of South Africa

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THE Union leads the African continent in the provision of social services for Africans, and rivals, proportionally to her national income, the most progressive western countries in the services which are available to Europeans. Her progress is revealed in the growth of Government expenditure from £11 million in 1911 to the £101 million of to-day. To meet the social programme which the Social and Economic Planning Council has mapped out and to which the Government is already in part committed, an expenditure of £160 million in 1955 will be necessary, *i.e.* three times the largest pre-war budget.

This gigantic task can only be achieved through substantial increases in the national income by way of greater productivity. If higher productivity can alone pay for a broadening and extension of the social services, a high national productivity is itself dependent on the development of health, education and social welfare. To date the growth of the social services has been encouraging : £9 million were spent by the Government in 1922-3, against £19 million in 1938-9 and £25 million to-day. But the Planning Council's programme will require the expenditure of £98 million in 1955 on social services.

The Union has been given two major blue prints for the further development of her social services : the report of the National Health Services

Commission and the Social Security Plan of the Select Committee. The first recommends a unified national health authority which is to administer a state run free medical service through the agency of 400 Health Centres and affiliated hospitals, a service financed in the main by a Health Tax which will exceed 8 per cent. of a person's income, costing at first not much more than what the Union is already spending on health but rising by 1955 to £20½ million.

An annual national outlay of £19.5 million on social security has been advocated by the Select Committee as the minimum "Beveridge" for South Africa, basing itself on the valuable Blue Book of the Social Security Committee. Increasing existing insurances and including the contingencies of birth, death and large families, the original committee had been ambitious enough to advocate an expenditure of £32 million and increasing benefits to Europeans by 179 per cent., for Coloureds and Asiatics by 285 per cent. and to Africans by 293 per cent.

### Public Health

Let us examine the present position. The country is spending some £14 million or 3.3 per cent. of its national income on health, a somewhat higher proportion than England and Wales. The comparable figures are as follows :

TABLE I.

Health expenditures in South Africa and in England and Wales.

Country	Cost per head of population £	National Income per head £	Proportion defrayed by the state %
South Africa .. ..	1.33	39	37
England and Wales .. ..	3.48	111	30

### Curative Services

On the curative side, with which all health services must begin since spectacular cures will alone gain the confidence of the people in modern science, the Union has more than 10,000 beds available for Europeans and slightly less than 10,000 for non-Europeans. If the recommendations of the Union Hospital Survey Committee of 1927 of a ratio of 1 bed to every 200 Europeans and 1 bed to every 700 non-Europeans be used as a standard, there is a need for an increase of 10 per cent. for Europeans and non-Europeans. However, the National Health Services Commission already demands a higher standard for non-Europeans, *viz.* a ratio equal to that of Europeans for Coloured and Asiatics, and a proportion of 1 : 500 for Africans, in which case the available non-European beddage would have to be doubled. The public has been scandalised by recent revelations according to which nine out of 28 Cape hospitals and 11 out of 18 Transvaal hospitals are over-

crowded. The worst case perhaps is the Johannesburg non-European hospital which was built to accommodate 400 patients, and has 506 beds with a daily average of 700 patients. To meet the demands for drastic reform a large military hospital on the precincts of Johannesburg has been promised to the non-Europeans. The advance achieved in the span of 14 years will appear from the following table :

TABLE II  
Proportion of persons per bed in 1927 and 1941. (General medical and surgical hospitals only).

Province	European		Non-European	
	1927	1941	1927	1941
Cape .. .. .	409	255	2,308	894
Transvaal . . .	294	217	2,831	920
Orange Free State ..	846	256	7,603	1,319
Natal .. .. .	160	111	1,429	625

Specialisation of institutions is a recent trend and shortfalls are therefore great. It is an encouraging sign that the population is rapidly taking to hospital confinements. In 1932 only 15 per cent. European children were born in institutions. In 1943 the figure had risen to 40 per cent. with an increase of 4 per cent. alone in the last year. Thirteen hundred beds are needed for Europeans and the same number for non-Europeans to accommodate the maternity cases. Special children's hospitals exist as yet only in the larger cities. Local authorities are in advance of their legal requirements in the provision of clinics in Native locations, some of which are in charge of female medical officers.

No deficiency of beds is found for Europeans suffering from infectious diseases, another obligation of the towns, but 2,000 beds are wanted for the non-Europeans. A little over 1,100 beds are wanted for both the European and the non-European chronically sick. Mental hospitals are badly overcrowded, 13,356 patients being accommodated in institutions meant for 11,735. Fifteen hundred orthopaedic beds are required. There are a number of separate V.D. hospitals which have been generously subsidised. Thirty thousand Europeans and 300,000 non-Europeans were treated in 1943 for venereal diseases. Desirable as all further advances may be the cost of additional hospital facilities must be considered. Twelve hundred pounds was the pre-war cost per bed, excluding equipment, of the Pretoria and Groote Schuur hospitals. Even if the costs can be met, the problem is not solved merely by a large-scale building programme. Personnel difficulties are very formidable. To take the case of mental nurses : there are 740 of them employed but the unfilled vacancies number 383. Seven thousand nurses and midwives are in practices but if the standard of one nurse per 500 persons is taken as a basis, 20,000 are needed. Greater training facilities, especially for non-Europeans, more attractive pay and working conditions and a diminution of the high turnover of female staff through marriage are among the chief requirements.

Splendid as the Union's achievements are she has quite clearly come to one of the critical phases of her development. Although from 55-71 per cent. of all patients are treated free of charge, to some extent services have been provided in the measure in which the consumer was able to pay for them. The standards quoted and the Commission's whole plan revolve around the concept of meeting health needs, irrespective of payability. This would require an entirely different distribution of many personnel services. Under the present system 70 per cent. of all doctors in Natal are concentrated in two towns. While there is one doctor to every 380 inhabitants of Cape Town there is only one to every 30,000 in Zoutpansberg. In the Commission's scheme of socialised medicine 10,000 doctors would be required against the present 2,853 and the number of dentists would have to be trebled.

It is a hopeful sign that the medical practitioners, more progressive than their confreres overseas, have themselves demanded such a re-orientation, while the Government provoked a plan of socialised medicine in its terms of reference to the National Health Services Commission which was to advise : "on the provision of an organised National Health Service in conformity with the modern conception of 'Health' which will ensure adequate medical, dental, nursing and hospital services for all sections of the people of the Union of South Africa."

The present set-up is governed by the Public Health Act of 1919, according to which local authorities are responsible for environmental services and the protection against epidemics, the provinces have to find the money for the establishment, maintenance, and management of all general hospitals and supervise the local authorities, while the central government caters for all residual services. A large amount of hospital work especially in rural areas depends on the missions, which maintain, mostly for Africans, 2,800 beds the cost of which is defrayed only to 10 per cent. by the state, 40 per cent. being paid by the patients themselves. Eleven per cent. of the Union's health expenditure is met by employers. The members of the defence and police force, of several public companies and all mines enjoy free hospitalisation. The Workmen's Compensation Act, the Miner's Phthisis Act, and the Factory Act, further protect the worker and are in line with most advanced overseas practice.

### **Preventive Services**

The greatest health service of the Union however is provided by nature. An open air life in brilliant sunshine is possible nearly all the year round, so that such common European diseases as rickets are practically unknown in South Africa. Nor has the Union to meet the chief scourges of tropical Africa such as sleeping sickness, dysentery, yellow fever; even malaria is confined to a few isolated river valleys.

The Union's bill of ill health is therefore run up rather by her social than by her physical conditions, as a consequence of the poverty of the population, as well as of its ignorance and unhygienic living conditions. Illiteracy and witch-craft beliefs, the persistence of practices adequate in the windswept, sunbleached countryside, but dangerous to health in urban areas combined with the heterogeneity of the population in language, custom, attitudes, standard of civilisation, enhance the difficulties in the path of speedy amelioration. The low density of the rural population and bad communications

reduce the effectiveness of the services. It has therefore been claimed that the building of bridges and all-weather roads would more readily improve the nation's health than any other single measure. On the other hand the increasing density and multiplicity of contacts provided by larger urban agglomerations is exposing the people, who have not yet built up any sort of immunity, to greater risks of infection. Tuberculosis, for instance, is taking a terrible annual toll among African townsmen.

Beside town planning the provision of clean water, the control of foods (South Africa was one of the first countries in the world to adopt stamping of meat passed for human consumption), disposal of refuse, local authorities have been charged with the provision of mass housing. The Housing Act of 1920 followed closely on the Public Health Act. The Government makes housing loans available to the poorer classes at three different rates of interest: the ruling market rate of 4 per cent., the sub-economic rate of  $\frac{3}{4}$  per cent. for "sub-economic" groups and the nominal rate of 1s. on £100 for the housing of the aged poor and totally unfit. In 23 years the following sums have been spent:

TABLE III  
The working of the Housing Act from 1920 to 1944.

Type of Loan	Loans approved (in '000.000 £)		Loans issued (in '000.000£)	Number of Houses Built	
	European	Non-European		European	Non-European
Economic ..	6.4	1.3	7.1	8,382	10,096
Sub-economic ..	2.9	11.7	8.6	4,636	34,695
Aged Poor ..	0.15	0.02	0.12	331	198
TOTAL .. ..	9.45	13.02	15.82	13,349	44,989

Lately the Act and machinery have been considerably strengthened. A new National Housing and Planning Commission and a full-time Director of Housing have been appointed to give technical assistance and push through the Government's ten year programme of 290,000 houses, which is "to be treated as a national emergency."

An all-Union nutrition survey was conducted in 1938 and revealed that more than half of the European and three-quarters of the Native school-going population was mal-nourished. A National Nutrition Council with technical sub-committees was set up in 1940 to investigate the improvement of food supplies and a Controller of Food Supplies was appointed in 1942 to reorganise their distribution. The Union has suffered comparatively little from war shortages and no rationing scheme was adopted, but wheaten products, eggs, and bread, were subsidised at the rate of £1 million in each season. While care for the feeding of mine workers goes back to the National Labour Regulations Act of 1911, one of the earliest dietary regulations in the

world, the Union embarked on feeding services more as an economic expedient in an effort to dispose of dairy surplus.

A school "milk and cheese" scheme was inaugurated at State expense in 1935 and a State-subsidised butter scheme was also introduced for the benefit of the poorer European and Coloured households in urban centres. One million four hundred thousand gallons of milk and over four million lbs. of butter were distributed under this scheme in 1942. Racial discrimination has been dropped in the margarine scheme which after long opposition is now being produced and is to be distributed to all sections of the population. Other foods have followed. In 1941-2, 40,000 nuts and in 1943-4, 172,000 nuts were distributed and £20,000 worth of deciduous fruit has found its way into poor homes. The number of sub-economic packets of citrus fruit has risen from 79,000 in 1941 to 980,000 in 1944. The nutritional services have become part of the health services. Soup kitchens are now no more run on a poor relief basis: just as free health services, they have lost all taint of pauperism. The new conception has been realised most successfully in the government's national school feeding scheme which gives the same free 2d. school meal to children of all classes and races.

A number of food clubs have been started by employers, municipalities and social agencies. Milk and vegetables are being sold at cost in several native locations. Altogether nearly £2 million are being spent on nutrition. What can be done in the rehabilitation of weedy, mal-nourished, neglected youths has been shown by the work of the Physical Training Battalion. According to one set of investigators it justifies the sanguine hope "that within a few months practically every sub-standard young person in the country could be educated to such a level of efficiency that he or she could be physically fit to undertake every responsible type of labour which might be allotted to him or her."

There are a number of other preventive services such as recreational facilities, school medical examinations, subsidisation of physical education, health education, port inspection, research which cannot be but mentioned here. The effectiveness of the health administration as a whole can be read off the European Life Table expectancy of life which is 58.95 years for males and 63.06 for females—higher than in England. The infantile mortality rate for Europeans was decreased from 89.77 in 1920 to 45.66 per 1,000 births (the English rate is 57). For Coloureds the rate is still 153.27 and for Asiatics 95.93. No vital statistics are available for Africans. The maternal mortality rate has fallen from 5.99 per 1,000 births in 1910 to 2.83 in 1942 for Europeans, Asiatics have a rate of 6.06 and Coloureds 5.1. Perhaps the most diagnostic index of sanitary conditions is the typhoid incidence rate which has fallen from 187.5 per 100,000 in 1921 to 42.5 in 1941 for the whole population.

### SOCIAL WELFARE

The Social Security Committee's Report has rightly been heralded as a new beginning in South Africa. As in other agricultural countries social assistance was long considered redundant. Poor relief was left to the Church, the family and neighbourly help. As late as 1908 the Transvaal Indigency Commission was hostile to government poor relief. It advocated that the aged and infirm were to be left to charitable agencies. A new departure came with the pensions legislation of the 20's and 30's. Non-contributory

old-age pensions were introduced in 1928 for Europeans and Coloureds commencing at the age of 65 for men and 60 for women. Since 1935 Indians may receive small sums. In 1944 Africans were included in the provisions, a revolutionary step in spite of the smallness of the allowance. At the same time the means test was liberalised and allowances increased. In 1936 pensions were first paid to blind Europeans and Coloureds in need of assistance. As a result of an amendment of the Act in 1944 Africans are now included within the scope of the Act. Invalidity pensions were available to Europeans since 1937. Now all races are covered. Grants are payable under the Children's Act of 1937 to parents or guardians of destitute children of Europeans and Non-Europeans (excluding rural Natives). There are however, as yet, few places of safety for Bantu children. In order to enable a mother to remain at home with children exhibiting physical, mental or behaviour disabilities parents allowances are paid to all races (excluding rural Natives). Indigents are entitled to poor relief. War Veterans Pensions, the Governor-General's War Fund grants, Ex-Soldiers Occupational Equipment schemes, grants made to the dependants of lepers, maternity allowances, tuberculosics allowances are some of the other state responsibilities.

The development has been rapid and the trend is clearly to include all races in the provisions, though at differential rates. State obligations are mounting steadily with an emphasis on preventive and rehabilitative aspects in preference to a system of mere "doling." Private welfare organisations of which there are some 1,000, engaging in 1938 some 4,100 workers (350 were paid) depend increasingly for their finance on state support. Social workers tend to-day to be drawn from among University graduates in social science. One-third of all organisations are associated with the Dutch Reformed Church, the traditional custodian of social work, but large progressive industrial organisations, the railways, mines, the armed forces, the Johannesburg Municipality have also entered the field with their own welfare departments.

The new outlook in social welfare found expression in the creation of a separate Department of Social Welfare in 1937. To-day it has a staff of more than 600, double the pre-war figure, and is spending some £1,780,000 as compared with £650,000 in 1938-9.

Among the mixed bag of its responsibilities are feeding services, 13 homes for the aged, 23 hostels for workers, the care of war refugee children from England, Poland and other countries, shipwrecked seamen, prisoners friends, 13,000 protected infants, 41 creches, 19 boys' and girls' clubs, research into social problems, probation officers, holiday camps, rent control, sheltered industries and training camps for the physically handicapped or disabled, work colonies and forestry settlements. Multifarious other activities—paupers graves, hospital almoners, sheltered employment for the psychopathic, birth control clinics, aid to pregnant mothers, juvenile affairs boards and occupational guidance officers, etc. are among the services imposed on, and met by, modern South Africa.

The public responds generously to social welfare appeals. In 1941 Johannesburg alone raised £970,000 for welfare purposes associated with the war effort, 29 per cent. of which went overseas. One hundred and fifty-four social agencies are active in the city on behalf of Europeans and 62 on behalf of non-Europeans.



A new step has been taken by the Government's decision to provide family allowances in respect to the third and subsequent children for all but Africans, whose family conditions are often obscure, and secondly to make unemployment insurance cover 700,000 instead of 230,000 workers. The benefits for the lower income groups will be doubled. Persons in receipt of unemployment benefit will not be excluded from other forms of assistance. There will be no limiting period during which benefits may be drawn.

The Government is planning for the following expenditure increases :

Item	1943 '000 £	1947-8 '000 £
Old Age Pensions .. .. .	2,500	7,000
Invalidity Grants .. .. .	203	1,750
Blind Persons and Grants .. .. .	194	350
Children's Act .. .. .	312	1,000
Family Allowances .. .. .	—	1,250
Unemployment .. .. .	122	2,000
Other Social Services .. .. .	662	3,000
	3,993	16,350

The optimism reflected in these figures may be taken as a demonstration of the nation's determination to win the peace. They indicate also that responsible opinion is now convinced that large scale social welfare measures can be introduced without undermining the ordinary man's will to work and to strive : a testimony finer than any, that the visions of the social planners have already become the common desire and common experience of the average South African.

## Medical Services in Southern Rhodesia

THE RT. HON. SIR GODFREY MARTIN HUGGINS,

C.H., K.C.M.G., F.R.C.S., M.P.

*Prime Minister of Southern Rhodesia.*

IT is estimated that there are about 120 practising doctors in Southern Rhodesia, that is one doctor to about 12,500 persons. It has been suggested in the Union of South Africa that the short-term objective should be one doctor to every 3,000 inhabitants, and a proposed ideal is one doctor to every 1,000. The work of mine and municipal medical officers in Southern Rhodesia is largely devoted to natives. For Europeans there are 684 beds in Government hospitals and 100 in municipal hospitals, giving an average of one bed per 100 Europeans. There is one bed per 250 non-Europeans, with an acute shortage of accommodation for native patients in some areas, such as Bulawayo and Salisbury.

Few statistics are available to throw light on the problem of malnutrition. Of the European school children examined in 1942, eight and a half per cent. were badly nourished, while this was true of 28 per cent. of the coloured children. Only six and a half per cent. of the European and one per cent. of the coloured children were above average.

In regard to the health conditions of natives in urban areas, serious overcrowding exists in some localities, and other undesirable features, such as back to back accommodation, await improvement. Some of the European rural and peri-urban townships have inadequate sanitation, while the native quarters in particular, suffer from insufficient light and verminous conditions. The native communities in and around the larger towns suffer to varying degrees from bad housing, lack of drainage, electric light, water supply and sewerage, with the attendant problems of flies and mosquitoes.

The total annual expenditure on health services of all kinds in the Colony is estimated to be nearly one million pounds (excluding the cost of medical services to the Royal Air Force). Of this, nearly a quarter of a million is paid to doctors; nearly 30 per cent. is expended in the running of Government hospitals and dispensaries; and nearly a quarter of a million is spent on dentistry, optical work, drugs, patent medicines and surgical and medical appliances. The remainder is spent on administration and preventive medicine by the Government and local authorities; on curative work by municipalities, missions and mines; and on chiropractors, district nurses and masseurs and other purposes. Practically half of this amount is provided by the Government (of which about £100,000 is of a wartime character). The Government, in addition, maintains hospitals and dispensaries, pays salaries of Government medical officers, meets general administrative costs, makes grants to municipalities and missions, provides for preventive work and research, and pays for medical services to the army, the police, paupers, prisons, internment camps, refugees and military dependants. Just over £200,000 is contributed by local government bodies, mines, missions, insurance companies, employers and medical aid societies. Private citizens provide the balance of about £300,000 (about £3 per man, woman and child).

Sick pay is an additional item, paid out under the Workmen's Compensation Act or by employers or trade unions.

Free treatment of any nature is available for the poor, but there is no comprehensive scheme for providing for the middle class against sickness. About 7,000 to 8,000 employees belong to medical aid societies, which help in the problem. There is provision under the Workmen's Compensation Act for sickness or accident caused by a man's work, but the incidence of this is small compared with sickness arising from other causes.

Considerable progress has been made in recent years in the erection of clinics for natives, but these are far from sufficient, and native prejudice against the hospitals is rapidly breaking down, with the result that many of the native hospitals in the towns are overcrowded. The establishment of clinics has played a big part in this health education.

There is little prospect of immediate improvement because of the shortage of staff, building supplies and labour, but the conditions are to be remedied as soon as possible. The impossibility of obtaining the additional staff required during the War, has been an insufferable handicap to progress, but when conditions return to normal big advances along the lines already laid out can be expected.

The natives have proved to be excellent nurses and medical orderlies, preventive and propagandist staff, and any post-war scheme will pay more attention to the training of non-European orderlies, nurses, sanitary inspectors, health visitors, health propagandists, doctors and dentists. The Medical Director is working out a scheme for the employment of 50 European sanitary inspectors. It is also expected that a native district nursing service will be created, to cover eventually the whole Colony. The emphasis in future developments is likely to be on the increase of preventive medicine measures, of which the above mentioned proposals will form and important part.

During the war the military dependants' medical aid scheme has been in operation. It has no unemployment benefits, as the father of the family is employed in the Forces. Under the scheme the patient chooses her own doctor, while the doctor's fees are guaranteed. The cost of the scheme for 7,165 dependants is £45,969. It includes medical fees (half fees at hospitals), specialist and consultant fees, surgical and anæsthetic fees, maternity (medical and nursing) fees, massage, travelling, nursing, theatre fees, x-ray fees, laboratory fees, chemists' charges, medicines and sera, but not dentistry.

Evidence is being collected from all sections of the community as a preliminary to the preparation of proposals for a new health scheme or schemes, that will take account of its scattered rural population; the large native population at a low standard of living; and the Colony's comparatively small resources. The Government may appoint a Commission to investigate the matter, if that is considered desirable after the Union Commission on Public Health has issued its report.

## Health Services in British Colonial Territories in Africa

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LORD HORDER once said that the object of a Health Service was to help the fit to remain fit, to raise the general standard of fitness, to control diseases due to preventable agents, and to cure or alleviate disease when it does occur. These may be said to be the aims of medical policy in the Colonial territories at the present time. But the medical services in the Colonies did not start with such aims in view. In most, if not in all of them, the Services began with the object of rendering medical aid to the early immigrants to the Colonies. It was only by gradual degrees that the advantages of European medicine became known to the native population and brought them to seek, in an increasing measure, the help of the European doctor. In the first place, therefore, such Government hospitals in the

Colonies as there were, only catered for European patients, though as time went on accommodation was made available for a certain number of African patients, particularly those in Government service. With changing outlook, more and more emphasis came to be laid on medical services for the local populations, and more and more hospitals were built specially for this purpose. To-day it may be said that in all British Colonial territories in Africa there is a more or less well developed system of hospitals for all races, with a feeder network of small hospitals or dispensaries surrounding them. In the larger hospitals specialist services are also provided, though not as yet on a very adequate scale. But while these clinical services have been coming into being, there have grown up, in addition, services which are directed to the prevention, rather than to the cure, of disease. Originally these services were on the lines of the sanitary services in towns in this country. But with increase of knowledge about tropical diseases, and the discovery that a very large number of the patients in hospitals suffer from diseases which are preventable if attacked at their source, the preventive services extended their scope to deal with all conditions affecting health, particularly in the rural areas. There was a tendency at the commencement of the preventive services to treat them as separate entities from the curative ones, and although they were both sections of the same Department, there was a definite division between the two, and to a certain extent, probably a certain amount of rivalry. Although in some of the Colonial territories this early tendency to dichotomy has not altogether disappeared from the medical organisation, in general it may now be said that medical administrators realise the essential unity of the curative and preventive sections, and the dangers inherent in the old arrangement. In most places the medical officer in charge of a district deals with both aspects of medical work. There are great advantages in this because, naturally, people tend to look on the man who cares for them when they are sick, as a friend and are consequently more willing to listen to him when he talks to them about preventive measures. On the other hand they are rather suspicious, and perhaps resentful, of some individual whom they do not know, telling them how to run their villages and how to look after their children and their houses.

This is a general, and perhaps over-simplified, story of the way the medical services in Colonial territories have grown up, and is essential for a proper understanding of the present position of medical services in British Africa, since it explains the apparently unbalanced character of these services in some of the territories, and the lack—inexplicable to a critic—of any co-ordinated plan for their simultaneous development in Colonial territories as a whole. It was indeed natural for each territory to develop first those aspects of the medical service for which it felt most need, so that most of them, like Topsy, just “grewed” into their present none-too-tidy form. Moreover different problems still confront different territories, and medical staffs are still far too small to deal with them all adequately, so that while every effort is being made to ensure that the health needs of Colonial populations are being met as far as can be, it should not surprise us to find that there is no one design which applies to the medical services in all Colonial territories. One could only deprecate it if there was, for it would tend to discourage those experiments in organisation and methods which are constantly being made in the hope of finding some new or quicker approach to better health.

In any discussion of Colonial medical policy, attention must be drawn to changes in outlook which have taken place in the past ten years. At one time medical services were looked upon as an independent unit of Government whose duties were limited to the cure of disease. Nowadays it is realised that the medical services are a part, and a very important part, of social welfare services generally, and that if the needs of the people are to be met at all levels, not only must a wider conception be taken of the activities of medical departments, but these must be co-ordinated with those of other services such as Agriculture and Veterinary Science, Education, Forestry, Administration, etc. The inter-dependence of all these Services is now recognised, and their policies are usually co-ordinated by the Development and Welfare Committees which have been set up in many territories.

But however well plans may be made and co-ordinated, they depend for their carrying out on the personnel available to do this. Doctors and nurses and health officials of various kinds are all necessary for the proper functioning of medical departments. In the early days such staff was drawn from this country, but being relatively expensive, was limited in numbers. So in all Colonial territories every effort has been made to augment imported staff by training personnel drawn from the local populations. The extent to which this has been possible varies in different territories in Africa, depending upon the standard of general education. In some Colonies where secondary education is advanced, medical schools exist in which students drawn from the local population, are trained up to, or nearly up to, the same standard as doctors in this country. In other Colonies where secondary education is not so developed, students of this calibre are not available. As a result the medical treatment in these latter territories is largely in the hands of European practitioners drawn from this country or from the Dominions, whereas in the former, European doctors play largely a supervisory or advisory part, the executive work being in the hands of locally trained medical practitioners. Similarly there are wide differences between territories in Africa in the training given to nurses. In some, girls drawn from the local population have been trained as nurses almost up to the same standard as in Britain. Indeed, some girls have been trained in British hospitals. In others, where female education has lagged behind that of males, dependence for nursing staff is largely placed on men trained usually on the apprenticeship system, men who work under the supervision of European nursing sisters drawn from this country or from the Dominions. But of all British territories in Africa it is now true to say that the aim is to bring the training of nurses and doctors, as soon as possible, up to the same standards as exist in this country. For that reason, the Education Departments are being urged—if urging is needed—to hasten the raising of educational standards so as to provide a supply of adequately educated girls and men for training for professional posts.

But however great the efforts of the educationists there will not, for many years to come, be doctors enough to meet the needs of the 40,000,000 inhabitants of Colonial territories in Africa. Dependence must, meanwhile, be placed upon an intermediate grade of staff which has been given the title of "Medical Aid" or "Hospital Assistant." The men so-named have usually had an initial training as a nurse and have been given additional training in the diagnosis and treatment of the common diseases of the country. They are in most cases men who have been selected for their intelligence and

character. These men form the additional hands which allow the doctor to extend his activities to a much larger area, and to deal with more patients and health problems than would otherwise be humanly possible. On the nursing side it is hoped to develop before long, a type of nurse who will live in the villages and combine the work, which in this country is carried out by the district nurse and health visitor. Such nurses are to be called "Community Nurses," and it may be that when their possibilities have been fully developed, much of the work of the medical aids will be taken over by them.

As has already been mentioned, Colonial medical policy rightly attaches the greatest importance to the essential indivisibility of the curative and preventive sections of the medical services. But for the purposes of an article such as this, the activities of one of these sections must unavoidably be described before those of the other. So in this description of the district medical arrangements to be found in many Colonial territories in Africa, the curative section will be dealt with first.

The central medical unit of the district consists of the hospital situated at the district headquarters. Here there are wards for male and female patients, and often special wards for maternity patients and for persons suffering from such diseases as tuberculosis or leprosy or dysentery. This is the headquarters of the district medical staff which usually consists of a European medical officer, with perhaps an African Assistant Medical Officer who has been trained in the regional medical school, or an Asian sub-Assistant Surgeon trained in India. Where there are no such Assistants, the Medical Officer is assisted by the medical aid. The district hospital forms the centre of the web and round it at varying distances, depending upon the ease of communication, are a series of dispensaries, staffed usually by medical aids or sometimes by locally trained Assistant Medical Officers. These dispensaries have large out-patient clinics and may have a certain number of beds in which cases can be retained for treatment, either permanently or while waiting for transfer to the district hospital. It is at the dispensaries that the mass treatment of certain diseases is usually carried out. Round each dispensary again there are aid-posts which may be opened once, twice or thrice a week, and are attended on these occasions by the medical aid or dresser from the dispensary. These aid-posts are for the convenience of the population in the area who might otherwise have to walk forty or fifty miles to get medical attention. Usually the aid-post only deals with patients who have already been seen at the dispensary or district hospital. In those territories where road communications are good, the hospital and dispensaries and aid-posts are usually linked up by an ambulance service which calls at the dispensaries, perhaps once or twice a week, and removes patients requiring more skilled treatment to the district hospital. Between these visits the ambulance is also on call to collect serious cases which cannot await the routine collection. The treatment given in the hospitals and dispensaries is free to the poor, and sometimes even to all, though charges may be made for the use of private wards. Treatment for all communicable diseases, important from the community point of view, such as yaws, venereal disease, tuberculosis, etc. is free.

The curative services in districts in the Colonies have, as already explained, in nearly all cases preceded any preventive measures, and in consequence it has usually proved convenient to base the preventive services on the hospitals

and dispensaries, converting them in effect into health units. In many of the Colonial territories the dispensaries and hospitals have attached to them a maternity unit where ante-natal clinics and child welfare clinics are held and maternity cases attended. These units are usually supervised by a European nursing sister and staffed by locally trained nurses and midwives. In recent years it has become common to require the staff of the dispensaries to undertake some school medical work, and a locally trained nurse is frequently attached to the dispensary where she looks after female patients in the morning and visits schools in the afternoon. But school health services have not been developed on a large scale up to the present time. At the dispensaries and hospital is also centred the staff dealing with sanitation. At the present time most territories are using locally recruited staff who have been trained as Sanitary Inspectors, some having taken the examination of the local branch of the Royal Sanitary Institute. Among their many duties are included the improvement of rural water supplies, the general sanitation of the villages, the prevention of nuisances, and the design and laying out of simple houses for villagers, etc. In general they may be said to act as health technicians for the general population. In the past there has been, in many places, too much importance attached to the inspection side of their duties. But in recent years stress has been laid in their training on the needs for them to secure their aims by persuasion rather than by reporting faults, and so to encourage the villagers to look on them as friends and not as policemen. It is hoped that a good deal of the work now done by the Sanitary Inspector will be taken over by community nurses when these are available as, being women, they will have a much better opportunity of gaining the confidence of the women of the village and securing their co-operation in sanitary measures.

To complete the picture of the district organisation, mention must be made of the specialist services which are provided at territorial headquarters. There are usually available specialists in surgery and medicine, and in some Colonies, in midwifery and gynaecology. There are also specialists in preventive medicine, particularly malariologists, venereal disease specialists, and in a few places, mental specialists and tuberculosis specialists. Recently specialists in eye diseases and those in ear, nose, and throat, have been added to the staff in one or two territories. As will be seen the organisation is still very fluid and by no means complete. Work in the past has always been cramped by the need for money. Hospitals are costly institutions to build and maintain, and European staff drawn from this country or the Dominions is also an expensive item. It will be impossible to provide medical services on an adequate scale until professional staff can be trained locally to take over the work. Hence both in East and West Africa, medical schools have been established for the training of local men and women as medical practitioners. Nursing schools also exist in certain territories and so do Sanitary Inspectors' schools. Perhaps more could be done by greater centralisation of this training, but in all these matters colonies are still feeling their way, particularly so in regard to the training of girls since parents object to their daughters going far from their homes and their personal supervision.

Within the limits of an article like this, it is not possible to give anything but an inadequate sketch of the medical services in British Colonial territories in Africa at the present time. To do justice to what has been accom-

plished with inadequate funds and staff, and in the face of the difficulties of climate and communications, would require a book. Undoubtedly there is great room for improvement both in extension of services and in bringing medical help nearer to the population—in some places people still have to walk fifty, or even a hundred miles, to get medical aid. In one district there is only one medical officer for a million people. But as rapidly as possible, particularly now that help is available from the Colonial Development and Welfare Fund, schemes are being made to make the health services in the Colonies better able to fulfil the aims set out in Lord Horder's dictum.





Sir Alfred Webb-Johnson, Bt.  
President of the Royal College of Surgeons  
as seen by Sallon

# Health Legislation and Policy

THE health services administered by the Ministry of Health, the Department of Health for Scotland, the Ministry of Education, the Local Authorities and other statutory bodies are all under review at the present time by Government and Parliament. In some fields, such as the school medical service, the Education Act of 1944 introduced many changes and extensions. The stage is set for a further advance in the development of the public health services.

During the last few years, and particularly under the impact of total war, the emphasis in public health policy has been noticeably shifting to the preventive aspects of medicine. The concept of "positive health" is slowly gaining recognition, and this trend is gradually influencing legislative measures. The emergence of the term "Social Medicine" is but one symbol of this changing outlook on health as it affects the individual and, ultimately, the nation. To an increasing extent it is being appreciated that health has no frontiers and that the State must concern itself with many aspects of the physical and mental well-being of the individual.

The public health system, as it exists to-day, is derived from two strains, in neither of which was prevention primarily concerned with the interests of the sick individual. These two strains were, broadly, the early provision against pestilence, and the poor law. The former, in the ultimate roots of its origin, was based upon fear—the fear of the sound man of the risk or imminence of disease. Consequently, it was logical that centuries ago the sick and the maimed were banned from the community. The leper was barred from human association; he was regarded as an enemy of society, and suspected of efforts to spread his own disease in order to multiply the number of his companions in misfortune. The legend inscribed by authority upon houses infected with the plague, "Lord, have mercy upon us," carried with it the implication that no mercy could be expected by the inmates from any other quarter.

Similarly, so far as it was derived from the poor law, the public health system was in origin equally unconcerned with the interests of the individual. It was directed towards the prevention of certain consequences to individuals, but primarily with the economic object that those individuals might not become chargeable to the poor rate. In both lines of its descent, therefore, the public health system had a standpoint and an atmosphere wholly alien from those which inform modern science. This content had changed radically by the twentieth century. The far-reaching discoveries during the past hundred years in medicine, nutrition and economics of welfare have informed and broadened public health policy. Nevertheless, there still linger—or did before the outbreak of the war in 1939—some strains of the old out-moded attitude in public health legislation. Our national institutions are tenacious of the mould in which they were originally cast; and it will be seen, and must not be forgotten, that in its most pregnant epochs our legislative progress was made under the spur of a succession of alarming invasions of pestilence. With pestilence and famine conquered, the main impetus towards reforms in public health during the past fifty years has derived from the momentum

of war—the Boer War, the War of 1914–18, and the War of 1939–45, which seems likely to provide the most powerful stimulus to further advances.

### **The Genesis of the Local Government Board**

After the disappearance of the great religious orders, who for centuries had concerned themselves with the sick and destitute, the condition of the poverty-stricken masses deteriorated and caused the gradual creation of the Elizabethan Poor Law, which found its final form in 1601. The Act of that date made each parish responsible for its own poor. From it developed the system of parish overseers, workhouses, apprenticeships for pauper children, and provision for lunacy which existed without radical change until it broke down under the strain of the new conditions created by the Industrial Revolution. Then it was replaced by the Poor Law Amendment Act of 1834, which set up the Boards of Guardians. It was not, however, until 1847 that the first public health official was appointed—Dr. Duncan, of Liverpool. Increasingly, as the rapid changes wrought by economic developments produced their effects, it became clear that drastic measures were needed to cope with the insanitary conditions of the new towns and cities. This need was illuminated by the work of such investigators as Chadwick, whose survey in 1842 disclosed the appalling wastage caused by preventable disease; by Farr in his masterly reports from the Registrar-General's office; and by Simon's study of the sanitary services.

The rapid expansion in the size of the population, the growth of towns and industries lacking the most elementary sanitary services, led to a deterioration in health. The evils of slum life, impure water, festering pools and non-existent drainage had far-reaching effects on the course of infectious disease and the spread and virulence of epidemics. Royal Commissions on drainage and sanitation succeeded each other with monotonous regularity. This state of affairs in conjunction with the menace of a fifth invasion of Asiatic Cholera pointed to the necessity for drastic reforms in the sphere of public health. But legislative measures were slow in coming.

The lineal ancestry of the present-day Ministry of Health begins with the Poor Law Commission, which was set up in 1834 to deal with the problem of indiscriminate poor relief, and which became the Poor Law Board under a parliamentary head in 1847. The Secretary of the Commission was Edwin Chadwick, a devoted admirer and pupil of Jeremy Bentham. His vigorous reports helped to focus public opinion on the grossly insanitary conditions prevailing, especially in the towns of that time; and in 1848 a General Board of Health was set up, of which Chadwick and Lord Shaftesbury were both members, and a Public Health Act was passed which provided easy machinery for establishing local sanitary authorities. Opposition was such, however, that the Board was reconstructed in 1854 and altogether abolished in 1858, though the local framework persisted and much of the Board's work continued to be performed by the Home Office or the Privy Council. But these administrative changes were found to be quite inadequate to deal with the environmental evils of the day. A strong Royal Commission recommended consolidation of the law and the establishment of both a uniform system of local government and a central authority which would absorb all other central government functions in relation to local authority health administration. The outcome, however, was not a Ministry of Health, but the Local

Government Board : a central authority responsible for the general supervision of all local authority functions, including much that was unrelated to health in any form. The Act of 1871 transferred to the new department the functions and staff of the Poor Law Board, the Local Government Act Office of the Home Secretary's Department, and the Medical Department of the Privy Council (in relation to local government), while the Registrar-General was made responsible to the Board instead of to the Secretary of State. The President of the Poor Law Board became President of the new Local Government Board ; and the administration of the functions united in the new Department was largely fused under a new secretariat recruited mainly from the Poor Law Board staff. Under the auspices of this new Department (upon which new functions under the Highways and Turnpikes Acts, the Alkali Acts and the Metropolitan Water Acts were conferred by an Act of 1872), the reform of local government on its constitutional and administrative side was undertaken.

### **Developments From 1871 to 1919**

Although the first English Public Health Act had been passed in 1848, that of 1875 was by far the most important measure during that period. It forms the basis of much of the structure of present-day legislation covering such matters as :—

water supply ; general sanitary provisions, including sewerage ; supervision of markets and slaughterhouses ; highways and streets and buildings ; labourers' dwellings ; common lodging houses ; public nuisances ; investigation of offensive trades ; provision against infection in suspected houses, etc., including destruction of infective bedding, etc., and removal of infected persons to hospital, including those coming in ships ; provision of hospitals ; appointment of officers—Medical Officer of Health, Surveyor, Inspector of Nuisances, Clerk and Treasurer ; appointment and proceedings of Committees ; rating and borrowing powers ; protection of officers from personal liability ; alteration of areas and union of districts ; constitution of Port Sanitary Authority, etc.

After the passing of this Act in 1875 the structure of local government was reorganised so as to place the direct administration of public health and welfare services, with the exception of the Poor Law service, in the hands of a single set of popularly elected bodies, the councils of counties, boroughs, urban and rural districts, known generically as " local authorities." County Councils were set up in 1889 to discharge most of the administrative functions previously performed by quarter sessions. Borough councils (or municipal corporations) have a very ancient history, but assumed their modern shape in 1835 and 1882. Urban and rural district councils were established in 1894 and took over the functions of the local sanitary authorities, inaugurated in 1848 and made universal in 1872.

The larger boroughs were called county boroughs and were independent of the counties ; elsewhere powers were divided between the councils of the counties and those of the boroughs, urban and rural districts contained in them. Poor relief was in the hands of popularly elected Boards of Guardians whose areas, except in rural districts, bore no relation to those of the local authorities just mentioned.

During this period modern systems of water supply, sewerage, and sewage

disposal, public cleansing and refuse disposal, bye-law control and provision for dealing with infectious disease became universal in all places of any size, and the first beginnings were made by a few local authorities in clearing the slums. A number of Boards of Guardians also developed their poor law infirmaries into well-equipped general hospitals.

In 1912 a radically new development in public health policy was inaugurated by the coming into force of the first National Health Insurance Act. The new scheme provided free medical treatment and sick pay for the general body of workers by the method of compulsory insurance financed by contributions from workers, employers and the national Exchequer. The scheme was administered centrally by a new Department, the National Health Insurance Commission; but much of the detailed work fell—as it still falls—on “Approved Societies,” who are mostly the old Benefit Societies, or “clubs,” and on local Insurance Committees. The local health authorities found no direct place in the new scheme.

In 1919 the process begun in 1871 was carried a stage further. The Local Government Board, the National Health Insurance Commission and functions of the Home Office in relation to mental diseases were merged in a new Ministry of Health which was endowed with enlarged functions to deal with all matters relating to the national health, and in particular with the pressing problem of working-class housing. Moreover, the wording of the Act showed that a considerable advance had been made in the conception of the duties of the central government in relation to national health. “It shall be the duty,” ran one Clause of the Act, “of the Minister in the exercise and performance of any powers and duties transferred to him by or in pursuance of this Act to take all such steps as may be desirable to secure the effective carrying out and co-ordination of measures conducive to *the health of the people*.” It was the health of the people which all the transferred powers were to subserve; not the narrower objects alone for which the separate powers transferred were originally created. Towards this end provision was made in the Act for all or any of the health functions of the Ministry of Pensions and the Board of Education to be transferred to the new Ministry. But these and other changes envisaged immediately after the war of 1914–18 have not taken place. Nor perhaps has the new Department completely fulfilled the expectations of its creators. Had it been otherwise, there would have been no need of further reconstruction at the present time.

### **The Inter-War Period**

Apart from the establishment of the Ministry of Health and the Scottish Board of Health (superseded by the Department of Health for Scotland in 1921) in 1919, the war of 1914–18 led to the creation of a number of new health and welfare services. The setting up of a venereal disease service in 1916 was a direct consequence of the war, while the “Fisher” Education Act of 1918 was probably the most important product of wartime influences. This Act, which envisaged, among other notable advances, a system of part-time education up to the age of eighteen, was followed in the same year by a comprehensive Maternity and Child Welfare Act. The Addison Housing Acts were passed in 1919; and in the following year non-contributory old-age pensions were made available for blind persons at the age of fifty, and local authorities were required to prepare blind welfare schemes.

In 1925 a third great social insurance scheme was introduced providing contributory pensions for widows, orphans and persons over sixty-five in the insured section of the population. Nevertheless, the Poor Law Authorities, who still remained unreformed, had to deal with vast numbers of persons whose needs were not satisfied by any of the new public social services. The workhouse test for the able-bodied was almost universally abandoned, and scales of home relief were made more generous. Eventually the financial difficulties of Boards of Guardians in areas of severe unemployment became so acute that it was impossible to postpone the reform of the administration. In 1929 the Local Government Act abolished the Boards of Guardians and transferred their main functions to the Public Assistance Committees of the county and county borough councils. In Scotland the parish councils had been responsible for the administration of poor relief since 1894, but the Local Government (Scotland) Act, 1929, transferred their Poor Law functions to the county councils and large burghs. At the same time it was provided that the special functions of the Poor Law authorities in both countries relating to blind welfare, hospital provision, and the care of destitute children, and of amentals and dementals, might be transferred to the appropriate special committees of the counties and county boroughs in England and Wales and of the counties and large burghs in Scotland, instead of being dealt with by public assistance committees. These powers have been used to a considerable extent, and, in particular, a great public hospital system has emerged in place of the old Poor Law Infirmaries.

The onset of the great depression in the early 1930's seriously interrupted this expansion of the health and social services, and many local authorities in the areas of heavy unemployment suffered badly by reductions in income while the demand for public services expanded. Several important acts were, however, passed in the decade before the war. Housing, town-planning, slum-clearance and overcrowding Acts were passed in 1930, 1932, 1935, and 1938. This period between the wars was noteworthy for a spectacular advance in the provision of new houses. In all, approximately 4,000,000 new houses were provided in twenty years. Other landmarks during the 1930's included the Midwives Act which came into force in 1936, and the Voluntary Pensions Scheme in 1938; while, in 1939, the first Cancer Act was introduced. The operation of the latter has, however, been held up by the war.

### **The Scope of the Health Services**

Although this historical survey has so far dealt, in the main, with those services for which the central Health Departments are responsible—the Ministry of Health and the Department of Health for Scotland—a large number of other Ministries are concerned with other aspects of health and welfare.

*The Board of Education (now the Ministry of Education)*: Partly through the disclosures of the Inter-Departmental Committee on Physical Deterioration, appointed after the Boer War, a series of advances were registered during the early part of the twentieth century in the care of school-children. In order to prevent the education of children being impaired by under-feeding, statutory powers to provide meals for children in public elementary schools were conferred on the local education authorities of England and

Wales by the Education (Provision of Meals) Act, 1906, and on the local education authorities of Scotland by the Education (Scotland) Act, 1908. The Scottish Act also conferred the power to provide clothing. These Acts were amended subsequently to enable local authorities to supply meals on holidays and other non-school days. In 1907 the Education (Administrative Provisions) Act imposed the duty on all English and Welsh local education authorities of providing medical inspection for school-children.

In 1921, under the Education Act, the supply of free meals to school-children was sanctioned, and this service was widened under the Milk in Schools Scheme, 1934. The war has resulted in great extensions in the provision of milk and meals in schools. As to the future, the new Education Act envisages a thorough overhauling and expansion of the School Medical Service, the Milk and Meals Schemes and other services such as the provision of boots and clothing to needy children.

### **The Ministry of Labour and the Ministry of Fuel**

The physical fitness of the people is naturally determined to an important extent by the conditions under which they work as well as by the ways in which they live and use their leisure. Therefore, to secure the health, safety and happiness of large numbers of factory, mine and shop workers, an elaborate code of legislation has been built up during the past one hundred years. For it has gradually been realised that decent working conditions are as important as decent living conditions, that overcrowding in a factory is as detrimental to health as overcrowding at home, and that long hours worked by women and children sap the stamina and morale of the race. In 1938 the Factories Act came into force, effecting a badly needed codification and modernisation of the law. As a result, the Factory Inspectorate has been greatly increased. The impact of the war on the industrial health services has led to revolutionary changes not only in administration but in the scope of the provision for occupational health and welfare. The responsibility for this service has been transferred from the Home Office to the Ministry of Labour and National Service and, as regards mining, from the Board of Trade to the Ministry of Fuel. More far-reaching changes in the services are envisaged in the increasing emphasis on rehabilitation, as illustrated, for example, in the Disabled Persons (Rehabilitation) Act. The Scottish experiments in social medicine such as the Clyde Basin Scheme and the establishment of Fitness Centres are further examples of the trend towards a new and positive conception of the duties of the State in relation to the health of the people.

In addition to the functions of these three departments concerned with the health of school-children, industrial workers and miners, there are other departments who have certain responsibilities in the broad field of the health services, for example, the Ministries of Supply and Transport, the Home Office, the General Post Office and the Board of Control (the latter under the Ministry of Health). Then there are a variety of statutory and semi-statutory bodies such as the Medical Research Council, the Central Council for Health Education, etc. Finally, there are a great number of voluntary organisations pioneering and experimenting in many fields of health and welfare. Shortage of space forbids any attempt to trace the historical development of all these bodies—statutory and voluntary.

### **The War**

The war of 1939-45, in common with previous conflicts, has acted as a catalyst in the sphere of public health. Great reforms and far-reaching legislative measures have been introduced under the dire necessity of protecting the health of the whole community. Under the impact of civil defence requirements, new responsibilities have been thrust on the Ministry of Health, the Ministry of Labour and other central Departments. These functions have, in the main, been decentralised and added to the work of local authorities. In support of these administrative changes the Regional Organisation of the Ministry of Health has been considerably expanded.

In the first three years of war alone there were over 200 Acts of Parliament, over 5,000 Orders and Regulations and tens of thousands of official circulars, ministerial directions, licences and so on. This immense flow of legislative business, much of it affecting directly or indirectly the health and welfare services, has placed a great burden on the machinery of local government.

It is not possible here to interpret in any detail this mass of legislation which the war has produced. How much of it will stand in the future no one can tell at the present time. But there is little doubt that some of the more important and basic changes that have occurred since 1939 will leave their mark on the future public health system of the country. The Emergency Hospital Scheme has brought into close association the voluntary hospitals and the Local Authority hospitals. Medical staffs have been re-distributed—to the benefit of many sections of the community—and hospitals have been improved and extended out of all recognition. A nationwide public health laboratory service has come into being to the great advantage of local authorities and the public they serve. A campaign has been launched by the Ministry of Health against three dangerous diseases—tuberculosis, venereal disease and diphtheria. The Government's policy of dispersal in time of war has left its mark on the health services in many areas where improvement was badly needed. These services, such as maternity and child welfare, water and sanitation and the school medical services, have had to improve owing to the demands from a greatly inflated population. The Government's policy of supplementary feeding has been of immeasurable benefit to the health of mothers and young children. These are some of the noteworthy advances that have been registered during the war. But in some fields, principally housing, the war has entailed not progress but retreat. This has been inevitable but as Government spokesmen have admitted, it will mean an immense programme of building for many years to come.

### **The Future**

The shape of the future public health services cannot yet be drawn. It will depend in part on the general form of reconstruction in those fields not primarily concerned with the major health services. Thus, the Government's final decisions on such proposals as the Uthwatt and Scott Reports and the ultimate results of the new Education Act—particularly as it affects the School Medical Service—will, in varying degrees, determine the shape and content of the new Health Services. Predominantly, however, the framework of these Services will be settled by the decisions which must emerge from the Government's proposals for "A National Health Service." In



the early part of 1944, these proposals were published in a White Paper (Cmd. 6502). They cover a very wide field ranging from the general administrative structure of the services, the hospital and consultant services, the general-practitioner service, the personal health services, finance, local government and allied matters. In the words of the White Paper the objective is "to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health ; that what they get shall be the best medical and other facilities available ; that their getting these shall not depend on whether they can pay for them, or on any other factor irrelevant to the real need—the real need being to bring the country's full resources to bear upon reducing ill-health and promoting good health in all its citizens."

The main features of the new National Health Service put forward for discussion by the Government may be summarised as follows. It is proposed that the new responsibility for providing the comprehensive service shall be put upon an organisation in which both central and local authority take part, and which both centrally and locally is answerable to the public in the ordinary democratic manner. Central responsibility will lie with the Minister, local responsibility will lie with the major local government authorities (the county and county borough councils) operating for some purposes severally over their existing areas, and for other purposes jointly over larger areas formed by combination. Both at the centre and locally, special new consultative bodies are proposed, for ensuring professional guidance and the enlistment of the expert view. At the centre, in addition, a new and mainly professional body is to be created to perform important executive functions in regard to general medical practice in the new service.

The new joint authorities, *i.e.*, the counties and county boroughs in combination, will be responsible (over suitable areas determined by the Minister after consulting local interests) for assessing the needs of those areas in all branches of the new service, and for planning generally how those needs should best be met. They will do this in consultation with the local professional bodies referred to, and they will submit their proposed arrangements to the Minister for final settlement in each case. Then, when each area plan is settled, the joint authority will have the duty of securing all the hospital and consultant services covered by it, by their own provision, and by arrangements with the voluntary hospital in the area ; and they will for this purpose be responsible in future for the existing local authority hospitals of all kinds. The individual county and county borough councils, making up the joint authority, will usually be responsible for local clinic and other services within the general framework of the plan, but there will be special provision for the child-welfare services, to ensure a close relation between them and child education. General medical practice in the new scheme will be specially organised, largely as a national and centralised service, but with proper links with the local organisation to relate it to the hospitals and to other branches of the service as a whole. There will be certain variations of these proposals for Scotland, to suit the differing circumstances there.

These proposals are still under discussion between the Ministry of Health and other interested bodies. Certain changes are envisaged which will alter the structure laid down in the White Paper. The subject is, however, reviewed in more detail in the special article "A National Health Service."

Other aspects of reconstruction in the field of the health and social services are also discussed in separate articles contained in this edition. The scope of the reforms now under way is extraordinarily wide, ranging from mental health to dentistry, and maternity to the care of old age pensioners. In some fields, such as financial aid, the first legislative measures have been passed, *i.e.*, the Act creating the Ministry of National Insurance and the Family Allowances Act. In others, the pattern to emerge is not yet clear. Moreover, the work of the Boundary Commission, established in 1945 to review Local Government areas, will vitally affect the local machinery which will have to administer and operate the health and social services of the future.

#### IMPORTANT DATES CONCERNING THE MINISTRY OF HEALTH

- 1801 First Census
- 1831 First Cholera Epidemic
- 1832 Parliamentary Franchise extended
- 1834 Poor Law Amendment Act. Poor Law Commission established
- 1835 Municipal Corporations Act
- 1837 Registration of Births, Marriages and Deaths
- 1848 Second Cholera Epidemic. General Board of Health established, with power to set up local sanitary authorities in certain areas
- 1852 Third Cholera Epidemic
- 1858 General Board of Health abolished
- 1867 Parliamentary Franchise extended
- 1868 Torrens Housing Act (slum clearance)
- 1871 Local Government Board established
- 1872 Local sanitary authorities made general
- 1875 Cross Housing Act (slum clearance)
- 1878 Public Health (Water) Act (rural water supply)
- 1882 Municipal Corporations Act
- 1884 Parliamentary Franchise extended
- 1888 Local Government Act (County Councils)
- 1894 Local Government Act (District and Parish Councils)
- 1899 London Government Act (Metropolitan Boroughs)
- 1907 School Medical Service
- 1908 Old Age Pensions
- 1909 First Town Planning Act
- 1912 National Health Insurance
- 1913 Mental Deficiency Act
- 1918 Women's Suffrage. Maternity and Child Welfare and Venereal Diseases services
- 1919 Ministry of Health established. Addison Housing Acts
- 1920 Blind Persons Act
- 1921 Public Health (Tuberculosis) Act
- 1923 Chamberlain Housing Act
- 1924 Wheatley Housing Act
- 1925 Rating and Valuation Act
- 1926 Widows', Orphans', and Old Age Contributory Pensions. Housing (Rural Workers) Act
- 1929 Local Government Act (Poor Law Guardians abolished; derating; block grant; revision of boundaries, etc.)
- 1930 Greenwood Housing Act (slum clearance). Mental Treatment Act

- 1932 Town Planning Act (built-up areas)
- 1935 Hilton Young Housing Act (overcrowding and redevelopment)
- 1936 Midwives Act
- 1938 Voluntary Pensions Scheme. Housing Act (consolidated subsidies for slum clearance and overcrowding; new subsidy for rural housing)
- 1939 Cancer Act

### **Ministry of National Insurance**

*The new Ministry took over on APRIL 1ST 1945 the duties assigned to it under the 1944 Act. These include specific functions hitherto exercised by the Ministry of Health and the Secretary of State for Scotland; the Ministry of Labour and National Service; and the Home Secretary. For a full statement of these functions see Section OFFICIAL STATEMENTS, MINISTRY OF NATIONAL INSURANCE.*

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(See also Supplement)

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unless otherwise indicated**

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36, Sydenham Road, Croydon, Surrey. (Telephone : Croydon 4686.)  
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**South Western**

T. N. Hill, "Parklands," Tyndall's Park Road, Bristol, 8.

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**North Midland**

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**North Eastern**

L. J. King, Coronet House, Queen Street, Leeds, 1.

**North Western**

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**Scotland**

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**Wales**

I. H. Thomas, Dominions House, Queen Street, Cardiff.

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Telephone : Abbey 1200.

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1, Richmond Street, Glasgow, C.1. Telephone : Bell 1605.

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**Central Midwives Board**

73, Great Peter Street, Westminster, London, S.W.1.

Telephone: Abbey 2414.

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## General Medical Council

44, Hallam Street, London, W.1.

Telephone : Langham 2727.

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*Members:* The Rt. Hon. Lord Moran of Manton, M.C., M.D.; Cecil Pembrey Grey Wakeley, C.B., F.R.C.S.; John Prescott Hedley, F.R.C.P.; Arthur William Mickle Ellis, M.D.; Henry Roy Dean, D.M.; Ronald Bramble Green, F.R.C.S.; Henry Stanley Raper, C.B.E., M.B.; Leonard Gregory Parsons, M.D.; Walter James Dilling, M.B.; Matthew John Stewart, M.B.; George Albert Clark, M.D.; Robert James Brocklehurst, D.M.; Alfred William Sheen, C.B.E., M.S.; Douglas James Acworth Kerr, M.D.; Henry Wade, C.M.G., D.S.O., F.R.C.S. (Ed.); Andrew Allison, M.B.; Sydney Alfred Smith, C.B.E., M.D.; Edward Provan Cathcart, C.B.E., M.D.; David Campbell, M.C., M.D.; William John Tulloch, O.B.E., M.D.; Thomas Gillman Moorhead, M.D.; Richard Atkinson Stoney, F.R.C.S. (Irel.); Myles Keogh, L.A.H.; Joseph Warwick Bigger, M.D.; Denis Joseph Coffey, M.B.; William James Wilson, M.D.; The Rt. Hon. Sir Douglas Hewitt Hacking, Bt., O.B.E., M.P.; Sir William Wilson Jameson, K.C.B., M.D.; Henry Cohen, M.D.; John Ritchie, M.B.; Charles Gibson

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## General Nursing Council for England and Wales

23, Portland Place, London, W.1. Telephone: Langham 2819 and 3375.

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*Statistical Branch:* Terra Nova School, Southport, Lancs.

*Central National Registration Office:* Smedley Hydro, Southport, Lancs.

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## King Edward VII Welsh National Memorial Association

The Temple of Peace and Health, Cathays Park, Cardiff.

Telephone: Cardiff 4728.

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*Secretary:* F. J. Alban, C.B.E., F.C.I.S., F.S.A.A.

*Principal Medical Officer:* Norman Tattersall, M.D.

*Director of Research:* W. H. Tytler, B.A., M.B. (The David Davies Professor of Tuberculosis at the Welsh National School of Medicine).

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Telephone : Waterloo 5000.

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*Prison Commissioners and Directors of Convict Prisons:* Alexander Paterson, M.C. ;  
J. C. W. Methven, M.R.C.S., L.R.C.P.

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## Miners' Welfare Commission

(Appointed by the Board of Trade under the Mining Industry  
(Welfare Fund) Act, 1939).

Ashley Court, Ashstead, Surrey. Telephone : Ashstead 3262.

*Chairman:* Major-Gen. The Rt. Hon. Sir Frederick Sykes, M.P.

*Chief Districts Officer:* R. Whiffeld Parker.

*Deputy Chief Districts Officer:* J. D. Herd.

*Chief Architect:* C. G. Kemp, A.R.I.B.A.

*Senior Architects:* J. A. Dempster, F.R.I.B.A., A.I.L.A. ; A. J. Saise, A.R.I.B.A.

*Chief Quantity Surveyor:* H. J. Rayner, F.S.I.

*Secretary :* A. D. Stedman, M.B.E.

*Assistant Secretaries:* T. A. Bennett, M.B.E. ; T. A. Freston.

# MEDICAL OFFICERS OF HEALTH OF ENGLAND AND WALES

## County Councils

- Anglesey** : Public Health Department, Glanaber, Llangefni. Dr. A. Davies.  
**Bedfordshire** : Shire Hall, Bedford. Dr. C. G. Welch.  
**Berkshire** : 11, Abbot's-walk, Reading. Dr. A. Richmond.  
**Brecknockshire** : County Health Offices, Watton Mount, Brecon. Dr. W. F. W. Betenson.  
**Buckinghamshire** : County Health Office, Aylesbury. Dr. G. W. H. Townsend.  
**Caernarvonshire** : County Offices, Caernarvon. Dr. D. E. Parry Pritchard.  
**Cambridgeshire** : Shire Hall, Castle Hill. Dr. R. French.  
**Cardiganshire** : County Health Offices, 56, Portland Street, Aberystwyth. Dr. Ernest Jones.  
**Carmarthenshire** : Shire Hall, Carmarthen. Dr. William M. Lloyd.  
**Cheshire** : 24, Nicholas Street, Chester. Dr. I. Campbell Mackay.  
**Cornwall** : County Hall, Truro. Dr. R. N. Curnow.  
**Cumberland** : 11, Portland Square, Carlisle. Dr. Kenneth Fraser.  
**Denbighshire** : Public Health Offices, 16, Grosvenor Road, Wrexham. Dr. H. A. Thomas.  
**Derbyshire** : County Offices, St. Mary's Gate, Derby. (Vacant.)  
**Devon** : 4, Barnfield Crescent, Exeter. Dr. L. M. Davies, Exeter.  
**Dorset** : Shire Hall, Dorchester. Dr. T. W. Stallybrass.  
**Durham** : Shire Hall, Durham. Dr. Ian McCracken.  
**Ely, Isle of** : County Hall, March. Dr. Hilda R. Hay.  
**Essex** : County Hall, Chelmsford. Dr. W. A. Bullough.  
**Flintshire** : County Buildings, Mold. Dr. A. E. Roberts.  
**Glamorgan** : Glamorgan County Hall, Cathays Park, Cardiff. Dr. A. R. Culley.  
**Gloucestershire** : Langham House, Berkeley Street, Gloucester. Dr. H. K. Cowan.  
**Herefordshire** : Shire Hall and County Offices, Bath Street, Hereford. Dr. S. W. Savage.  
**Hertfordshire** : County Hall, Hertford. Dr. J. L. Dunlop.  
**Huntingdon** : County Offices, Huntingdon. Dr. N. H. Harrison.  
**Kent** : County Hall, Maidstone. Dr. C. W. Ponder.  
**Lancashire** : County Offices, Preston. Dr. F. Hall.  
**Leicestershire** : 17, Friar Lane, Leicester. Dr. J. A. Fairer.  
**Lincolnshire (Holland)** : County Hall, Boston. Dr. W. G. Booth.  
**Lincolnshire (Kesteven)** : County Offices, Sleaford. Dr. J. H. Clarke.  
**Lincolnshire (Parts of Lindsey)** : County Offices, Newland, Lincoln. Dr. W. S. H. Campbell.  
**London, County of** : County Hall, Westminster Bridge, London, S.E.1. Sir Allen Daley.  
**Merioneth** : County Offices, Dolgelly. Dr. E. Lewys-Lloyd.  
**Middlesex** : 10, Great George Street, Westminster, London, S.W.1. Dr. H. M. C. Macaulay.  
**Monmouth** : County Hall, Newport. Dr. D. Rocyn Jones.  
**Montgomery** : County Offices, Welshpool. Dr. Ivor John Jones.  
**Norfolk** : 29, Thorpe Road, Norwich. Dr. T. Ruddock-West.  
**Northamptonshire** : County Offices, Guildhall Road, Northampton. Dr. C. M. Smith.  
**Northumberland** : County Hall, Newcastle-upon-Tyne. Dr. J. B. Tilley.  
**Nottinghamshire** : Shire Hall, Nottingham. Dr. A. C. Tibbits.  
**Oxfordshire** : 1, Becket Street, Oxford. Dr. H. C. Jennings.  
**Pembrokeshire** : County Offices, Haverfordwest. Dr. H. Middleton, M.C.  
**Radnorshire** : County Buildings, Llandrindod Wells. Dr. Mary D. Owen.  
**Rutland** : Ketton, Stamford. Dr. C. Rolleston.  
**Shropshire** : College Hill House, Shrewsbury. Dr. W. Taylor.  
**Soke of Peterborough** : County Council Offices, Bridge Street, Peterborough. Dr. C. Rolleston.

**County Councils—continued.**

**Somerset** : County Hall, Taunton. Dr. J. F. Davidson, O.B.E.  
**Southampton** : "The Castle," Winchester. Dr. H. L. Cronk.  
**Staffordshire** : County Buildings, Stafford. Dr. W. D. Carruthers.  
**Suffolk (East)** : County Hall, Ipswich. Dr. G. A. Atkinson.  
**Suffolk (West)** : Westgate House, Bury St. Edmunds. Dr. H. Roger.  
**Surrey** : County Hall, Kingston-on-Thames. Dr. J. Ferguson.  
**Sussex (East)** : County Hall, Lewes. Dr. R. A. Glegg.  
**Sussex (West)** : County Hall, Chichester. Dr. J. S. Bradshaw.  
**Warwickshire** : Shire Hall, Northgate Street, Warwick. Dr. C. F. Brockington.  
**Westmorland** : County Hall, Kendal. Dr. J. F. Dow ; Dr. Jessie M. L. Wright.  
**Wight, Isle of** : County Hall, Newport. Dr. J. Fairley.  
**Wiltshire** : County Hall, Trowbridge. Dr. C. E. Tangye.  
**Worcestershire** : County Buildings, Worcester. Dr. W. Parker, M.C., C.B.E.  
**Yorkshire (East Riding)** : County Hall, Beverley. Dr. Ralph Watson.  
**Yorkshire (North Riding)** : County Hall, Northallerton. Dr. J. A. Fraser.  
**Yorkshire (West Riding)** : County Hall, Wakefield. (Vacant.)

**County Boroughs**

**Barnsley (Yorks.)** : Town Hall. Dr. J. Tudor Lewis.  
**Barrow-in-Furness (Lancs.)** : Town Hall. Dr. A. R. Forrest.  
**Bath (Somerset)** : Guildhall, High Street. Dr. J. F. Blackett.  
**Birkenhead (Ches.)** : 9, Hamilton Square. Dr. D. Morley Mathieson.  
**Birmingham (War.)** : Council House. Dr. H. P. Newsholme.  
**Blackburn (Lancs.)** : Health Office, Victoria Street. Dr. V. T. Thierens.  
**Blackpool (Lancs.)** : Municipal Health Centre, Whitegate Drive. Dr. George W. Murray.  
**Bolton (Lancs.)** : Civic Centre. Dr. R. M. Galloway.  
**Bootle (Lancs.)** : Town Hall. Dr. F. T. H. Wood, O.B.E.  
**Bournemouth (Hants.)** : Town Hall. Dr. H. G. Smith.  
**Bradford (Yorks.)** : Town Hall. Dr. J. J. Buchan.  
**Brighton (Sussex)** : Royal York Buildings, Old Steine. Dr. Rutherford Cramb.  
**Bristol (Glos.)** : Kenwith Lodge, Westbury Park. Dr. R. H. Parry.  
**Burnley (Lancs.)** : 29, St. James' Street. Dr. D. C. Lamont.  
**Burton-upon-Trent (Staffs.)** : Town Hall. Dr. W. Alcock.  
**Bury (Lancs.)** : Municipal Offices, Bank Street. Dr. K. K. Wood.  
**Canterbury (Kent)** : Public Health Department, 20a, Stow Street. Dr. W. Goronwy Evans.  
**Cardiff City (Glam.)** : City Hall, Cathays Park. Dr. J. Greenwood Wilson.  
**Carlisle (Cumb.)** : Town Hall. Dr. J. C. B. Craig.  
**Chester (Ches.)** : Town Hall. Dr. J. W. Lobban.  
**Coventry (War.)** : Council House. Dr. A. Massey, C.B.E.  
**Croydon (Surrey)** : 20, Katharine Street. Dr. Oscar M. Holden.  
**Darlington (Durham)** : Greenbank, Dr. G. A. Dawson.  
**Derby (Derbyshire)** : Tenant Street. Dr. G. Lilico.  
**Dewsbury (Yorks.)** : Municipal Buildings, Halifax Road. Dr. C. G. Payton.  
**Doncaster (Yorks.)** : Wood Street. Dr. J. F. Galloway.  
**Dudley (Worcs.)** : The Council House, Priory Road. Dr. W. K. Dunescombe.  
**Eastbourne (Sussex)** : Town Hall. Dr. John Fenton.  
**East Ham (Essex)** : Town Hall, East Ham, London, E.6. Dr. M. E. Barker.  
**Exeter (Devon)** : Municipal Offices, 5, Southernhay West. Dr. G. F. B. Page.  
**Gateshead (Durham)** : Greenesfield House. Dr. James Grant.  
**Gloucester (Glos.)** : Priory House. Dr. Charles Cookson.  
**Great Yarmouth (Norfolk)** : Town Hall. Dr. D. Wainwright.  
**Grimsby (Lincs.)** : Municipal Offices, Town Hall Square. Dr. W. H. Taylor.  
**Halifax (Yorks.)** : Powell Street. Dr. G. C. F. Roe.  
**Hastings (Sussex)** : Summer Fields. Dr. G. R. Bruce, O.B.E.  
**Huddersfield (Yorks.)** : Town Hall, Ramsden Street. Dr. J. M. Gibson.  
**Ipswich (Suffolk)** : Elm Street. Dr. J. W. Hunter.  
**Kingston-upon-Hull (Yorks.)** : Guildhall. Dr. N. Gebbie.

**County Boroughs—continued.**

- Leeds (Yorks.)** : Health Office, Market Hall. Dr. J. Johnstone Jervis.  
**Leicester (Leics.)** : la, Greyfriars. Dr. E. K. Macdonald.  
**Lincoln (Lincs.)** : Beaumont Manor. Dr. Mohan Lal Bery.  
**Liverpool (Lancs.)** : Municipal Buildings. Dr. W. M. Frazer, O.B.E.  
**Manchester (Lancs.)** : Town Hall. Dr. C. Metcalfe Brown.  
**Merthyr Tydfil (Glam.)** : Town Hall. Dr. T. H. Stephens.  
**Middlesbrough (Yorks.)** : Municipal Buildings. Dr. T. Lloyd Hughes, Barrister-at-Law.  
**Newcastle-upon-Tyne (Northumb.)** : Town Hall. Dr. I. Earle McCracken.  
**Newport (Mon.)** : Health Department, Royal Chambers. Dr. H. W. Catto.  
**Northampton (Northants.)** : 7, St. Giles' Square. Dr. S. Rowland.  
**Norwich (Norfolk)** : Churchman House, St. Giles. Dr. Victor F. Soothill.  
**Nottingham (Notts.)** : Guildhall. Dr. Cyril Banks.  
**Oldham (Lancs.)** : Town Hall. Dr. J. T. C. Keddie.  
**Oxford (Oxon.)** : "Greyfriars," Paradise Street. Dr. G. C. Williams.  
**Plymouth (Devon)** : Town Hall, Stonehouse. Dr. T. Peirson.  
**Portsmouth (Hants)** : Municipal Offices, Royal Beach Hotel, Southsea. Dr. A. B. Williamson.  
**Preston (Lancs.)** : Municipal Building. Dr. F. A. Sharpe.  
**Reading (Berks.)** : Town Hall. Dr. S. L. Wright.  
**Rochdale (Lancs.)** : Town Hall. Dr. J. Innes.  
**Rotherham (Yorks.)** : Frederick Street. Dr. W. Barr.  
**St. Helens (Lancs.)** : Town Hall. Dr. F. Hauxwell.  
**Salford (Lancs.)** : 143, Regent Road. Dr. J. L. Burn.  
**Sheffield (Yorks.)** : Town Hall. Dr. J. Rennie.  
**Smethwick (Staffs.)** : The Uplands, Hales Lane. Dr. Hugh Paul.  
**Southampton (Hants.)** : Municipal Offices, Civic Centre. Dr. H. C. Maurice Williams, O.B.E.  
**Southeast-on-Sea (Essex)** : Municipal Health Centre, Warrior Square. Dr. J. Stevenson Logan.  
**Southport (Lancs.)** : Town Hall. Dr. W. E. Fitzgerald, M.C.  
**South Shields (Durham)** : Stanhope Road. Dr. W. Campbell Lyons.  
**Stockport (Ches.)** : Town Hall. Dr. J. Yule.  
**Stoke-on-Trent (Staffs.)** : St. Peter's Chambers. Dr. A. Wotherspoon.  
**Sunderland (Durham)** : Town Hall, Fawcett Street. Dr. A. S. Hebblethwaite, M.C.  
**Swansea (Glam.)** : The Guildhall. Dr. H. R. Tighe.  
**Tynemouth (Northumb.)** : Town Hall, Saville Street, N. Shields. Dr. R. H. Dawson.  
**Wakefield (Yorks.)** : Town Hall. Dr. F. Allardice.  
**Wallasey (Ches.)** : Town Hall, Brighton Street. Dr. R. B. Berry.  
**Walsall (Staffs.)** : Council House, Lichfield Street. Dr. J. A. M. Clark.  
**Warrington (Lancs.)** : Health Offices, Sankey Street. Dr. Stuart F. Allison.  
**West Bromwich (Staffs.)** : Town Hall. Dr. William S. Walton, G.M.  
**West Ham (Essex)** : 88, Romford Road, London, E.15. Dr. E. Ashworth Underwood.  
**West Hartlepool (Durham)** : Municipal Buildings. Dr. J. W. McKeggie.  
**Wigan (Lancs.)** : Municipal Buildings, Library Street. Dr. Henry Whitehead.  
**Wolverhampton (Staffs.)** : Health Offices, Red Lion Street. Dr. R. H. H. Jolly.  
**Worcester (Worcs.)** : Guildhall. Dr. A. J. B. Griffin.  
**York (Yorks.)** : Guildhall. Dr. Catherine B. Crane.

## Metropolitan Boroughs

- Battersea** : 204, Lavender Hill, S.W.11. Dr. G. Macdonald.  
**Bermondsey** : Municipal Offices, Spa Road, S.E.16. Dr. D. M. Connan.  
**Bethnal Green** : Town Hall, Patriot Square, E.2. Dr. Vynne Borland.  
**Camberwell** : Town Hall, Peckham Road, S.E.5. Dr. Howell Wood Barnes.  
**Chelsea** : 43, Manor St., Chelsea, S.W.3. Dr. W. H. L. McCarthy, Barrister-at-Law.



**Metropolitan Boroughs—continued.**

- Deptford** : Deptford Town Hall, New Cross Road, S.E.14. Dr. F. L. Keith.  
**Finbury** : Town Hall, Rosebery Avenue, E.C.1. Dr. A. B. Stewart.  
**Fulham** : Town Hall, Fulham, S.W.6. Dr. J. A. Scott, O.B.E.  
**Greenwich** : Town Hall, Greenwich High Road, S.E.10. Dr. C. Porter.  
**Hackney** : Town Hall, Mare Street, E.8. Dr. G. H. Dart, Barrister-at-Law.  
**Hammersmith** : Town Hall, King Street, W.6. W. H. Brodie (Temp.).  
**Hampstead** : Town Hall, Haverstock Hill, N.W.3. Dr. G. C. Trotter.  
**Holborn** : Town Hall, 197, High Holborn, W.C.1. Dr. J. A. Struthers.  
**Islington** : Town Hall, Upper Street, N.1. Dr. Victor Freeman.  
**Kensington** : Town Hall, Kensington, W.8. Dr. James Fenton, C.B.E.  
**Lambeth** : Lambeth Town Hall, Brixton Hill, S.W.2. Dr. A. G. G. Thompson.  
**Lewisham** : Town Hall, Catford, S.E.6. Dr. John W. Miller.  
**London, City of** : Guildhall, E.C.2. Dr. Charles F. White, O.B.E.  
**Paddington** : 14, Park Place Villas, Paddington, W.2. Dr. Geoffrey E. Oates.  
**Poplar** : Poplar Town Hall, Bow Road, E.3. Dr. G. O. Mitchell.  
**St. Marylebone** : Town Hall, Marylebone Road, N.W.1. Dr. H. A. Bulman.  
**St. Pancras** : Town Hall, Euston Road, N.W.1. Dr. D. H. Geffen.  
**Shoreditch** : Town Hall, Old Street, E.C.1. Dr. E. H. R. Smithard.  
**Southwark** : Town Hall, Walworth Road, S.E.17. Dr. W. Stott.  
**Stepney** : Queen Mary College, Mile End Road, E.1. Dr. F. R. O'Shiel.  
**Stoke Newington** : Town Hall, Church Street, Stoke Newington, N.16. Dr. S. King.  
**Wandsworth** : Municipal Buildings, Wandsworth, S.W.18. Dr. F. G. Galey.  
**Westminster** : City Hall, Charing Cross Road, W.C.2. Dr. A. J. Shinnie.  
**Woolwich** : Town Hall, Wellington Street, Woolwich, S.E.18. (Vacant.)

## MEDICAL OFFICERS OF HEALTH OF SCOTLAND

### County Councils

- Aberdeen** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Angus** : County Buildings, Forfar. Dr. J. Macfarlane Thomson.  
**Argyll** : Public Health Offices, Oban. Dr. J. A. C. Guy.  
**Ayr** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Banff** : County Offices, Banff. Dr. D. I. Walker.  
**Berwick** : County Offices, Duns. Dr. A. A. McWhan.  
**Bute** : 5, Learmonth Terrace, Edinburgh, 4. Professor J. R. Currie.  
**Caithness** : County Buildings, Wick. Dr. G. Dick.  
**Clackmannan** : County Buildings, Alloa. Dr. J. A. Roughead.  
**Dumbarton** : 88, College Street, Dumbarton. Dr. S. Harvey.  
**Dumfries** : County Buildings, Dumfries. Dr. J. Ritchie.  
 (Hirkmalive Parish) 1, Charlotte Street, Dumfries. Dr. J. G. Hunter.  
**East Lothian** : County Buildings, Haddington. Dr. A. D. Campbell.  
**Fife** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Inverness** : County Buildings, Inverness. Dr. A. M. Fraser.  
**Kincardine** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Kinross** : County Offices, Perth. Dr. D. J. McLeish.  
**Kirkcudbright** : County Offices, Kirkcudbright. Dr. A. Fraser.  
**Lanark** : County Offices, Hamilton. Dr. A. G. Reekie.  
**Midlothian** : 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.  
**Moray and Nairn** : New County Buildings, Elgin. Dr. I. C. Monro.  
**Nairn** : New County Buildings, Elgin. Dr. I. C. Monro.  
**Orkney** : County Buildings, Kirkwall. Dr. W. B. Bannerman.  
**Peebles** : 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.

**County Councils—continued.**

**Perth-Kinross** : County Offices, Perth. Dr. J. Kelman.  
**Renfrew** : County Buildings, Paisley. Dr. J. S. M. Gray.  
**Ross and Cromarty** : County Buildings, Dingwall. Dr. J. L. Horne.  
**Roxburgh** : County Offices, Newtown, St. Boswells. Dr. J. R. Adam.  
**Selkirk** : Technical College, Galashiels. Dr. G. M. Elliot.  
**Stirling** : County Offices, Stirling. Dr. E. N. Reid.  
**Sutherland** : Public Health Office, Bonar Bridge. Dr. K. A. Macrae.  
**West Lothian** : 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell ; Dr. L. Howie ; and Dr. J. Hunter.  
**Wigtown** : Douglas House, Newton Stewart. Dr. J. Macdonald Ross.  
**Zetland** : Brentham Place, Lerwick. Dr. S. A. B. Black.

## County Burghs

**Aberchirder** : County Offices, Banff. Dr. D. I. Walker.  
**Aberdeen** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Aberfeldy** : County Offices, Perth. Dr. D. J. McLeish.  
**Aberlour** : County Offices, Banff. Dr. D. I. Walker.  
**Abernethy** : County Offices, Perth. Dr. D. J. McLeish.  
**Airdrie** : Royal Buildings, Airdrie. Dr. R. J. Lumsden.  
**Alloa** : County Buildings, Alloa. Dr. J. A. Roughead.  
**Alva** : County Buildings, Alloa. Dr. J. A. Roughead.  
**Alyth** : County Buildings, Forfar. Dr. J. Macfarlane Thomson (Acting).  
**Annan** : County Buildings, Dumfries. Dr. J. Ritchie.  
**Arbroath** : 48, Hill Street, Arbroath. Dr. N. S. Setton.  
**Ardrossan** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Armadales** : Martindale, Bo'ness. Dr. J. Hunter.  
**Auchtermarder** : County Offices, Perth. Dr. D. J. McLeish.  
**Auchtermuchty** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Ayr** : 34, Newmarket Street, Ayr. Dr. R. L. Leask.  
**Ballater** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Banchory** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Banff** : County Offices, Banff. Dr. D. I. Walker.  
**Barhead** : County Buildings, Paisley. Dr. J. S. M. Gray.  
**Bathgate** : Martindale, Bo'ness. Dr. J. Hunter.  
**Biggar** : County Offices, Hamilton. Dr. J. McCallum Lang.  
**Blairgowrie and Rattray** : County Offices, Perth. Dr. D. J. McLeish.  
**Bo'ness** : 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.  
**Bonnyrigg and Lasswade** : Viewpark, Bonnyrigg. Dr. C. W. Somerville.  
**Brechin** : County Buildings, Forfar. Dr. J. Macfarlane Thomson (Acting).  
**Bridge-of-Allan** : County Offices, Stirling. Dr. E. N. Reid.  
**Buckhaven and Methil** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Buckle** : 1, Castle Street, Banff. Dr. J. C. Galloway.  
**Burghead** : County Buildings, Elgin. Dr. R. Douglas.  
**Burntisland** : St. Brendan, Burntisland. Dr. J. M. Logie.  
**Callander** : County Offices, Perth. Dr. D. J. McLeish.  
**Campbeltown** : Public Health Offices, Oban. Dr. J. A. C. Guy.  
**Carnoustie** : County Buildings, Forfar. Dr. J. Macfarlane Thomson (Acting).  
**Castle Douglas** : County Offices, Kirkcudbright. Dr. A. Fraser.  
**Clydebank** : Municipal Buildings, Clydebank. Dr. T. M. Hunter.  
**Coatbridge** : Municipal Buildings, Coatbridge. Dr. R. Cordiner.  
**Cockenzie** : County Buildings, Haddington. Dr. A. D. Campbell.  
**Coldstream** : County Offices, Duns. Dr. A. A. McWhan.  
**Coupar-Angus** : County Offices, Perth. Dr. D. J. McLeish.  
**Cove and Kilcreggan** : 88, College Street, Dumbarton. Dr. J. Lauder Thomson.  
**Cowdenbeath** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Crail** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Crief** : Vacant.  
**Cromarty** : County Buildings, Dingwall. Dr. J. L. Horne.  
**Cullen** : County Offices, Banff. Dr. D. I. Walker.  
**Culross** : County Buildings, Cupar. Dr. G. M. Fyfe.

**County Burghs—continued.**

- Cumnock and Holmhead** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Cupar** : Briarmount, Ladybank. Dr. J. A. Morris.  
**Dalbeattie** : County Offices, Kirkcudbright. Dr. A. Fraser.  
**Dalkeith** : Eskbank, Dalkeith. Dr. H. S. Ballantyne.  
**Darvel** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Denny and Dunipace** : County Offices, Stirling. Dr. E. N. Reid.  
**Dingwall** : County Buildings, Dingwall. Dr. J. L. Horne.  
**Dollar** : County Buildings, Alloa. Dr. J. A. Routhead.  
**Dornoch** : Public Health Office, Bonar Bridge. Dr. K. A. Macrae.  
**Doune** : County Offices, Perth. Dr. D. J. McLeish.  
**Dufftown** : County Offices, Banff. Dr. D. I. Walker.  
**Dumbarton** : Glencairn House, Dumbarton. Dr. C. C. Slorach.  
**Dumfries** : Municipal Chambers, Dumfries. Dr. E. Mills.  
**Dunbar** : County Buildings, Haddington. Dr. A. D. Campbell.  
**Dunblane** : County Offices, Perth. Dr. D. J. McLeish.  
**Dundee** : 9, West Bell Street, Dundee. Dr. W. L. Burgess, *C.B.E.*  
**Dunfermline** : Douglas Street, Dunfermline. Dr. C. B. Reekie.  
**Dunoon** : Public Health Offices, Oban. Dr. J. A. C. Guy.  
**Duns** : County Offices, Duns. Dr. A. A. McWhan.  
**East Linton** : County Buildings, Haddington. Dr. A. D. Campbell.  
**Edinburgh** : Public Health Chambers, Johnston Terrace, Edinburgh. Dr. W. G. Clark.  
**Elgin** : Vacant.  
**Elie and Earlsferry** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Ellon** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Eyemouth** : County Offices, Duns. Dr. A. A. McWhan.  
**Falkirk** : Arnotdale, Falkirk. Dr. J. Walker.  
**Falkland** : Briarmount, Ladybank. Dr. J. A. Morris.  
**Findochty** : County Offices, Banff. Dr. D. I. Walker.  
**Forfar** : 53, East High Street, Forfar. Dr. J. E. Cable.  
**Forres** : County Buildings, Elgin. Dr. R. Douglas.  
**Fortrose** : County Buildings, Dingwall. Dr. J. L. Horne.  
**Fort William** : County Buildings, Inverness. Dr. A. M. Fraser.  
**Fraserburgh** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Galashiels** : Technical College, Galashiels. Dr. G. M. Elliot.  
**Galston** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Gatehouse** : County Offices, Kirkcudbright. Dr. A. Fraser.  
**Girvan** : County Buildings, Ayr. Dr. C. A. Bignold.  
**Glasgow** : 23, Montrose Street, Glasgow, C.1. Sir A. S. M. Macgregor, *O.B.E.*  
**Golspie and Rogart** : County Offices, Golspie. Dr. J. D. Glaister.  
**Gourock** : County Buildings, Paisley. Dr. J. S. M. Gray.  
**Grangemouth** : The Grange, Grangemouth. Dr. J. G. Anderson.  
**Grantown-on-Spey** : County Buildings, Elgin. Dr. R. Douglas.  
**Greenock** : 3, Shaw Place, Greenock. Dr. A. Johnstone.  
**Haddington** : County Buildings, Haddington. Dr. A. D. Campbell.  
**Hamilton** : Municipal Buildings, Hamilton. Dr. W. Gilmour.  
**Hawick** : County Offices, Newtown, St. Boswells. Dr. J. R. Adam.  
**Helensburgh** : 39, Colquhoun Street, Helensburgh. Dr. A. G. Ingram.  
**Huntly** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Inverary** : County Offices, Inverary. Dr. W. P. Gracie.  
**Innerleithen** : 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.  
**Inverbervie** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Invergordon** : Tullochard, Alness. Dr. F. Macrae.  
**Inverkeithing** : County Buildings, Cupar. Dr. G. M. Fyfe.  
**Inverness** : County Buildings, Inverness. Dr. A. M. Fraser.  
**Inverurie** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.  
**Irvine** : Redhurst, Irvine. Dr. J. Wilson.  
**Jedburgh** : County Offices, Newtown, St. Boswells. Dr. J. R. Adam.  
**Johnstone** : Graham Street, Johnstone. Dr. M. Symington.  
**Keith** : County Offices, Banff. Dr. D. I. Walker.  
**Kelso** : County Offices, Newtown, St. Boswells. Dr. J. R. Adam.  
**Kilmarnock** : Grange Street, Kilmarnock. Dr. B. R. Nisbet.

**County Burghs—continued.**

- Kilrenny, Anstruther Easter and Anstruther Wester :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Kilsyth :** Brownswood, Bishopbriggs. Dr. J. B. Miller.
- Kilwinning :** County Buildings, Ayr. Dr. C. A. Bignold.
- Kinghorn :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Kingussie :** County Buildings, Inverness. Dr. A. M. Fraser.
- Kinross :** County Offices, Perth. Dr. D. J. McLeish.
- Kintore :** 4, Albyn Place, Aberdeen. Dr. H. J. Rae.
- Kirkcaldy :** County Offices, Kirkcaldy. Dr. J. R. W. Hay, M.C.
- Kirkcudbright :** County Offices, Kirkcudbright. Dr. A. Fraser.
- Kirkintilloch :** Brownswood, Bishopbriggs. Dr. J. B. Miller.
- Kirkwall :** County Buildings, Kirkwall. Dr. W. B. Bannerman.
- Kirriemuir :** County Buildings, Forfar. Dr. J. Macfarlane Thomson (Acting).
- Ladybank :** Briarmount, Ladybank. Dr. J. A. Morris.
- Lanark :** County Offices, Hamilton. Dr. J. McCallum Lang.
- Langholm :** County Buildings, Dumfries. Dr. J. Ritchie.
- Largs :** County Buildings, Ayr. Dr. C. A. Bignold.
- Lauder :** County Offices, Duns. Dr. A. A. McWhan.
- Laurencekirk :** 4, Albyn Place, Aberdeen. Dr. H. J. Rae.
- Lerwick :** Brentham Place, Harbour Street, Lerwick. Dr. J. Walker.
- Leslie :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Leven :** Barnet, North Links, Leven. Dr. R. B. Graham.
- Linlithgow :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Loanhead :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Lochelly :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Lochgilphead :** County Offices, Lochgilphead. Dr. J. D. McCallum.
- Lochmaben :** County Buildings, Dumfries. Dr. J. Ritchie.
- Lockerbie :** County Buildings, Dumfries. Dr. J. Ritchie.
- Lossiemouth :** Vacant.
- Macduff :** 1, Castle Street, Banff. Dr. J. C. Galloway.
- Markinch :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Maybole :** 18, Cassillis Road, Maybole. Dr. R. M. Walker.
- Melrose :** County Offices, Newtown, St. Boswells. Dr. J. R. Adam.
- Millport :** Redhurst, Irvine. Dr. J. Wilson.
- Milngavie :** 88, College Street, Dumbarton. Dr. J. Lauder Thomson.
- Moffat :** County Buildings, Dumfries. Dr. J. Ritchie.
- Monifieth :** 25, South Tay Street, Dundee. Dr. W. Gorrie.
- Montrose :** County Buildings, Forfar. Dr. J. Macfarlane Thomson (Acting).
- Motherwell and Wishaw :** Airbles Road, Motherwell. Dr. D. Ferguson.
- Musselburgh :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Nairn :** County Buildings, Elgin. Dr. R. Douglas.
- Newburgh :** Briarmount, Ladybank. Dr. J. A. Morris.
- New Galloway :** County Offices, Kirkcudbright. Dr. A. Fraser.
- Newmilns and Greenholm :** County Buildings, Ayr. Dr. C. A. Bignold.
- Newport :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Newton Stewart :** Douglas House, Newton Stewart. Dr. J. Macdonald Ross.
- North Berwick :** County Buildings, Haddington. Dr. A. D. Campbell.
- Oban :** Public Health Offices, Oban. Dr. J. A. C. Guy.
- Old Meldrum :** 4, Albyn Place, Aberdeen. Dr. H. J. Rae.
- Paisley :** 14, Gilmour Street, Paisley. Dr. G. V. T. McMichael.
- Peebles :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Penicuik :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Perth :** City Chambers, Perth. Dr. F. F. Main.
- Peterhead :** 4, Albyn Place, Aberdeen. Dr. H. J. Rae.
- Pittenweem :** County Buildings, Cupar. Dr. G. M. Fyfe.
- Port Glasgow :** County Buildings, Paisley. Dr. J. S. M. Gray.
- Portknowkie :** County Offices, Banff. Dr. D. I. Walker.
- Portsoy :** 1, Castle Street, Banff. Dr. J. C. Galloway.
- Prestonpans :** County Buildings, Haddington. Dr. A. D. Campbell.
- Prestwick :** County Buildings, Ayr. Dr. C. A. Bignold.
- Queensferry :** 10, Drumsheugh Gardens, Edinburgh, 3. Dr. J. Riddell.
- Renfrew :** County Buildings, Paisley. Dr. J. S. M. Gray.

**County Burghs—continued.****Rosehearty** : 4, Albyn Place, Aberdeen. Dr. J. H. Rae.**Rothies** : Vacant.**Rothsay** : 5, Learmonth Terrace, Edinburgh, 4. Professor J. R. Currie.**Rutherglen** : 14, Albany Drive, Rutherglen. Dr. C. Cross.**St. Andrews** : County Buildings, Cupar. Dr. G. M. Fyfe.**St. Monance** : County Buildings, Cupar. Dr. G. M. Fyfe.**Saltcoats** : 34, Ardrossan Road, Saltcoats. Dr. J. G. Campbell.**Sanquhar** : County Buildings, Dumfries. Dr. J. Ritchie.**Selkirk** : Technical College, Galashiels. Dr. G. M. Elliot.**Stewarton** : County Buildings, Ayr. Dr. C. A. Bignold.**Stirling** : Municipal Buildings, Stirling. Dr. R. Lockhart, M.C.**Stonehaven** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.**Stornoway** : Coathill Crescent, Stornoway. Dr. R. S. Doig.**Stranraer** : Douglas House, Newton Stewart. Dr. J. Macdonald Ross.**Stromness** : County Buildings, Kirkwall. Dr. W. B. Bannerman.**Tain** : St. Duthers House, Tain. Dr. H. Ross.**Tayport** : County Buildings, Cupar. Dr. G. M. Fyfe.**Thurso** : County Buildings, Wick. Dr. G. Dick.**Tillicoultry** : County Buildings, Alloa. Dr. J. A. Roughead.**Tobermory** : Public Health Offices, Oban. Dr. J. A. C. Guy.**Tranent** : County Buildings, Haddington. Dr. A. D. Campbell.**Troon** : County Buildings, Ayr. Dr. C. A. Bignold.**Turriff** : 4, Albyn Place, Aberdeen. Dr. H. J. Rae.**Whitburn** : Martindale, Bo'ness. Dr. J. Hunter.**Whithorn** : Douglas House, Newton Stewart. Dr. J. Macdonald Ross.**Wick** : County Buildings, Wick. Dr. G. Dick.**Wigtown** : Douglas House, Newton Stewart. Dr. J. Macdonald Ross.**OVERSEAS SECTION****Australia****OFFICE OF THE HIGH COMMISSIONER**

Australia House, London, W.C.2. Telephone : Temple Bar 1567.

*High Commissioner* : The Rt. Hon. S. M. Bruce, P.C., C.H., M.C.**COMMONWEALTH DEPARTMENTS :****PRIME MINISTER'S DEPARTMENT**

Commonwealth Offices, West Block, Canberra, A.C.T.

*Prime Minister* : The Rt. Hon. J. B. Chifley, M.P.*Secretary* : F. Strahan, C.V.O., C.B.E.**FOOD CONTROL**

Reliance House, 301, Flinders Lane, Melbourne.

*Chairman of Executive* : The Hon. W. J. Scully, M.P.*Members* : The Hon. J. B. Chifley, M.P. ; The Hon. J. J. Dedman, M.P.*Controller-General* : J. F. Murphy, C.M.G.

**DEPARTMENT OF HEALTH**

Civic Centre, Canberra.

*Minister:* Senator the Hon. J. M. Fraser.

*Private Secretary:* H. M. Bathurst.

*Director-General of Health and Director of Quarantine:* Dr. J. H. L. Cumpston, C.M.G.

*Senior Medical Officers:* Dr. M. J. Holmes, D.S.O. ; Dr. F. McCallum ; Dr. R. E. Richards ; Dr. H. E. Downes.

*Director, Commonwealth Serum Laboratories,* Parkville, Victoria : Dr. F. G. Morgan.

*Director, School of Public Health and Tropical Medicine,* The University, Sydney, New South Wales : Professor Harvey Sutton, O.B.E.

*Director, Australian Institute of Anatomy,* Canberra : Dr. F. W. Clements.

**NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL**

c/o Department of Health, Civic Centre, Canberra.

*Chairman:* Dr. J. H. L. Cumpston, C.M.G.

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**DEPARTMENT OF SOCIAL SERVICES**

East Row, City, Canberra, A.C.T.

*Minister:* Senator The Hon. J. M. Fraser.

*Private Secretary:* H. M. Bathurst.

*Director-General:* F. H. Rowe.

**SCIENTIFIC ADVISORY COMMITTEE ON FOODSTUFFS**

c/o Department of Commerce and Agriculture,  
337, Collins Street, Melbourne.

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*Members:* Dr. J. R. Vickery, Dr. I. W. Wark, H. R. Marston, Dr. W. J. Wiley (C.S.I.R.); Ross Grant, F. Wigan, I. McC. Stewart, H. C. Menzies, W. M. Carne (Department of Commerce and Agriculture); C. Massey (Department of the Navy); Major T. Peddle (Department of the Army); Squadron Leader O. A. Mendelshon (Department of Air); Dr. F. W. Clements (Department of Health); J. Douglass (Department of Supply and Shipping); Lieut.-Col. Sir Stanton Hicks (Professor of Physiology, University of Adelaide); H. E. West (William Angliss Food School).

*Secretary:* H. C. Menzies.

(The Committee is associated with the Department of Commerce and Agriculture).

**DEPARTMENT OF LABOUR**

Nicholas Building, 37, Swanston Street, Melbourne.

*Minister:* The Hon. E. J. Holloway, M.P.

*Secretary:* Dr. Roland Wilson, C.B.E.

*Director, Industrial Welfare Division:* R. G. Baxter.

**New South Wales****GOVERNMENT OFFICES**

Wellington House, 125, Strand, London, W.C.2.

Telephone : Temple Bar 4164.

*Acting Official Secretary:* A. W. Sutton.

**GOVERNMENT OF NEW SOUTH WALES**

Executive Buildings, Sydney.

*Premier and Colonial Treasurer:* The Hon. W. J. McKell, M.L.A.

**DEPARTMENT OF LABOUR AND INDUSTRY  
AND SOCIAL SERVICES**

A.P.A. Building, 53, Martin Place, Sydney.

*Minister:* The Hon. Hamilton Knight, M.L.A.

*Under-Secretary:* C. J. Bellmore.

*Industrial Registrar and Assistant Under-Secretary:* S. W. Ebsworth,  
B.A., LL.B.

*Director, Government Relief and Manager, State Labour Exchanges:*  
D. P. Witheriff.

**PUBLIC HEALTH DEPARTMENT**

Winchcombe House, 52, Bridge Street, Sydney.

*Minister:* The Hon. C. A. Kelly, M.L.A.

*Under-Secretary:* C. J. Watt.

*Director-General of Public Health:* E. S. Morris, M.D., Ch.M., D.P.H., F.R.A.C.P.

*Director, Division of Social Hygiene:* J. C. Booth, M.B., B.S.

*Director, Maternal and Baby Welfare:* Grace J. Cuthbert, M.B., Ch.M.

*Medical Officer and Chief Medical Referee, Workers' Compensation Commission:* H. K. Denham, B.A., LL.B., M.B., Ch.M.

### **GOVERNMENT INSURANCE OFFICE**

Bridge and Macquarie Streets, Sydney.

*General Manager:* M. G. Cooke, B.Ec.

### **EDUCATION DEPARTMENT**

Bridge Street, Sydney.

*Minister:* The Hon. R. J. Heffron, M.L.A.

*Under-Secretary:* J. G. McKenzie, B.A., B.Ec.

### **HOUSING DEPARTMENT**

Corner Bridge and Hunter Streets, Sydney.

*Minister:* The Hon. J. McGirr, M.L.A.

## **Queensland**

### **OFFICE OF THE AGENT-GENERAL**

409-410, Strand, London, W.C.2. Telephone: Temple Bar 3224.

*Agent General:* L. H. Pike.

### **GOVERNMENT OF QUEENSLAND**

Executive Buildings, Brisbane, Queensland.

*Premier and Chief Secretary:* The Hon. F. A. Cooper, M.L.A.

### **DEPARTMENT OF LABOUR AND INDUSTRY**

Treasury Buildings, Queen Street, Brisbane.

*Minister:* The Hon. V. C. Gair, M.L.A.

*Under-Secretary:* F. E. Walsh.

*Director of Employment (State Employment Council):* A. C. Sorensen.

### **DEPARTMENT OF HEALTH AND HOME AFFAIRS**

William Street, Brisbane.

*Minister:* The Hon. T. A. Foley, M.L.A.

*Under-Secretary:* R. H. Robinson.

*Director-General of Health Services and Medical Services:* Sir Raphael Cilento, M.D., B.S.

*Director of Physical Education:* E. V. Harris.



*Director of State Children's Department:* W. Smith.

*Director of Maternal and Child Welfare Services:* T. Henry R. Mathewson,  
M.B.

### **STATE GOVERNMENT INSURANCE OFFICE**

Adelaide Street, Brisbane.

*Commissioner of Workers' Compensation Department:* J. A. Watson.

### **NEW SETTLERS' LEAGUE**

King House, Queen Street, Brisbane.

*Secretary:* Miss C. M. Clayton.

### **DEPARTMENT OF PUBLIC INSTRUCTION**

Treasury Buildings, Queen Street, Brisbane.

*Minister for Education:* The Hon. J. Larcombe, M.L.A.

*Director of Education:* L. D. Edwards, M.A.

*Director of School Health Services:* L. St. Vincent Welch, M.R.C.S.

### **WORKERS' DWELLINGS DEPARTMENT**

Treasury Buildings, Queen Street, Brisbane.

*Manager:* J. E. Grenning

## **South Australia**

### **OFFICE OF THE AGENT GENERAL**

South Australia House, Marble Arch, London, W.1.

Telephone: Mayfair 5061.

*Agent General:* Sir Charles McCann.

### **GOVERNMENT OF THE STATE OF SOUTH AUSTRALIA**

Treasury Buildings, Flinders Street, Adelaide.

### **DEPARTMENT OF HEALTH**

*Chief Secretary, Minister of Health and Minister of Mines:* The Hon. A. L. McEwin, M.L.C.

*Under-Secretary:* F. G. Byrne.

*Director-General of Medical Services:* L. W. Jeffries, D.S.O., O.B.E.,  
M.B., B.S.

### **DEPARTMENT OF SOCIAL SERVICES**

*Under-Chief Secretary:* The Hon. A. L. McEwin, M.L.C.

*Secretary, Children's Welfare and Public Relief Department:* Clarence G. Lewis.

*Director of Education:* Dr. C. E. Fenner.

*Commissioner of Police:* W. F. Johns.

*Sheriff and Controller of Gaols and Prisons:* S. G. Blackman.

*Chairman, Central Board of Health:* A. R. Southwood, E.D., M.D., M.S.,  
M.R.C.P., F.R.San.I.

## **Tasmania**

### **OFFICE OF THE AGENT GENERAL**

Australia House, Aldwych, London, W.C.2.

Telephone : Temple Bar 9471.

*Agent General:* Sir Claude James.

### **GOVERNMENT OF TASMANIA**

Hobart, Tasmania.

### **DEPARTMENT OF PUBLIC HEALTH**

*Minister:* The Hon. E. R. A. Howroyd.

*Acting Director and Secretary:* E. J. Tudor.

### **EDUCATION DEPARTMENT**

*Minister:* The Hon. R. Cosgrove.

*Director:* G. V. Brooks, O.B.E.

*Secretary and Chief Education Officer:* C. E. B. Fletcher, M.A.

### **SOCIAL SERVICES DEPARTMENT**

*Minister:* The Hon. C. E. Culley.

*Director:* H. R. Read.

## **Victoria**

### **OFFICE OF THE AGENT GENERAL**

Victoria House, Melbourne Place, London, W.C.2.

Telephone : Temple Bar 2656.

*Acting Agent General:* A. H. Wright, I.S.O.

### **GOVERNMENT OF VICTORIA**

State Public Offices, Melbourne.

### **HEALTH DEPARTMENT**

*Minister:* The Hon. Ian Macfarlane, K.C., M.L.C.

*Chief Officer of Health:* H. H. Featonby, M.B., B.S., D.P.H.

### **EDUCATION DEPARTMENT**

*Minister:* The Hon. T. T. Holloway, M.L.A.

*Director of Education:* J. A. Seitz, M.A., B.C.E.

**NATIONAL FITNESS COUNCIL OF VICTORIA**

*Organiser:* Dr. A. G. Scholes.

**EMPLOYMENT COUNCIL OF VICTORIA**

*Chairman:* The Hon. Sir George Goudie, M.L.C.

*Secretary:* A. G. Coulthard.

**WORKERS' COMPENSATION**

*Minister:* The Hon. H. J. T. Hyland, M.L.A.

*Registrar:* G. T. Smith.

**Western Australia****OFFICE OF THE AGENT GENERAL**

Savoy House, 115, Strand, London, W.C.2.

Telephone : Temple Bar 8601.

*Agent General:* The Hon. M. F. Troy.

**GOVERNMENT OF WESTERN AUSTRALIA**

Perth, Western Australia.

**DEPARTMENT OF PUBLIC HEALTH**

*Minister:* The Hon. A. H. Panton, M.L.A.

*Commissioner for Public Health:* (Vacant).

**EDUCATION DEPARTMENT**

*Minister:* The Hon. J. T. Tonkin, M.L.A.

*Director of Education:* M. Little, M.A.

**DEPARTMENT OF SOCIAL SERVICES**

*Minister for Social Services:* The Hon. J. T. Tonkin, M.L.A.

**CHILD WELFARE DEPARTMENT**

*Secretary:* F. E. Meachem, J.P.

**Canada****OFFICE OF THE HIGH COMMISSIONER**

Canada House, London, S.W.1. Telephone : Whitehall 9741.

*High Commissioner:* The Rt. Hon. Vincent Massey.

**DEPARTMENT OF NATIONAL HEALTH AND WELFARE**

Federal Department of Health, Ottawa, Ontario.

*Minister:* The Hon. Brooke Claxton.

*Deputy Minister (Welfare):* George F. Davidson, Ph.D.

*Deputy Minister (Health):* Major-Gen. G. B. Chisholm, C.B.E., M.C.,  
E.D., M.D.

### PROVINCIAL DEPARTMENTS OF HEALTH

#### **Alberta**—*Department of Public Health.*

*Minister:* Dr. W. W. Cross.

*Deputy Minister:* Dr. M. R. Bow.

*Secretary:* L. A. Patterson.

*Superintendent of Public Health Nursing Division:* Miss H. McArthur.

*Medical Inspector of Hospitals:* Dr. A. Somerville.

*Supervisor of Municipal Hospitals:* E. E. Maxwell.

#### **British Columbia**—*Provincial Secretary's Department.*

*Provincial Secretary:* The Hon. G. S. Pearson.

*Deputy Provincial Secretary:* P. Walker.

*Provincial Health Officer:* Dr. G. F. Amyot.

*Assistant Provincial Health Officer:* Dr. J. S. Cull.

*Inspector of Hospitals:* P. Ward.

#### **Manitoba**—*Department of Health and Public Welfare.*

*Minister:* The Hon. Ivan Schultz.

*Deputy Minister:* Dr. F. W. Jackson.

*Director of Health:* Dr. C. R. Donovan.

*Director of Local Health Services:* Dr. C. E. Mather.

*Director of Health Education:* Miss M. Nix.

#### **New Brunswick**—*Department of Health and Social Services.*

*Minister:* The Hon. F. McGrand, M.D.

*Chief Medical Officer:* Dr. Charles W. MacMillan.

*Director of Public Health Nursing Service:* Miss Muriel Hunter, R.N.

#### **Nova Scotia**—*Department of Public Health.*

*Minister:* The Hon. F. R. Davis, M.D., C.M.

*Chief Health Officer:* Dr. P. S. Campbell, C.M., O.B.E.

*Superintendent of Public Health Nurses:* Miss Margaret MacKenzie.

#### **Ontario**—*Department of Health.*

*Minister:* The Hon. R. P. Vivian, M.B.

*Deputy Minister:* Dr. B. T. McGhie, C.M.

*Assistant Deputy Minister:* Dr. K. G. Gray, K.C.

*Chief Medical Officer:* Dr. J. T. Phair.

*Director of Hospitals:* Dr. R. C. Montgomery.

*Inspector of Hospitals:* C. J. Telfer.

**Prince Edward Island**—*Department of the Provincial Secretary, Treasurer and Public Welfare.*

*Minister:* The Hon. William Hughes.

*Provincial Health Officer:* B. C. Keeping.

**Quebec**—*Ministry of Health and Social Welfare.*

*Minister:* The Hon. J. H. A. Paquette, M.D.

*Deputy Minister:* Dr. Jean Gregoire.

*Assistant Deputy Minister:* Dr. J. C. Beaudet.

*Chief of Staff, Director of Health Services:* Dr. A. Lapierre.

**Saskatchewan**—*Department of Public Health.*

*Minister:* The Hon. T. C. Douglas, B.A., M.A.

*Deputy Minister:* Dr. R. O. Davison.

*Director of Hospital Administration:* Dr. C. F. W. Hames, B.A.

*Medical Officer:* Dr. J. W. Lord.

*Director of Nursing Services:* Miss E. Smith.

## India

### OFFICE OF THE HIGH COMMISSIONER

India House, Aldwych, London, W.C.2.

Telephone: Temple Bar 8484.

*High Commissioner:* Sir S. Runganadhan, M.A.

### DEPARTMENT OF EDUCATION, HEALTH AND LANDS NEW DELHI

*\*Minister-in-Charge: Member of the Council of the Governor-General:* The Hon. Sardar Sir Jogendra Singh.

*Secretary:* J. D. Tyson, C.B.E., I.C.S.

*Director-General, Indian Medical Service:* Lieut.-Gen. J. B. Hance, C.I.E., O.B.E., M.D., B.Ch.Camb., M.R.C.S., F.R.C.S.Ed., K.H.S., I.M.S.

*Public Health Commissioner with the Government of India:* Lieut.-Col. E. Cotter, C.I.E., M.B., B.Ch.(N.U.I.), D.P.H.Lond., I.M.S.

*Chief Lady Superintendent, Auxiliary Nursing Service:* Miss E. E. Hutchings.

\* Member of the Council of the Governor General.

### PROVINCIAL PUBLIC HEALTH AND MEDICAL DEPARTMENTS

#### ASSAM (Shillong)

*Governor:* His Excellency Sir Andrew Gourlay Clow, M.A., K.C.S.I., C.I.E., I.C.S.

**Public Health Department**

*Director:* Dr. S. H. Paul, L.R.C.P., M.R.C.S., D.P.H., D.T.M.

**Medical Department**

*Inspector-General of Civil Hospitals and Prisons:* Lieut.-Col. H. E. Shortt.

**BENGAL (Calcutta)**

*Governor:* His Excellency the Rt. Hon. Richard Gardiner Casey, C.H., D.S.O., M.C.

(The Governor recently took over powers of the Minister of Public Health and Local Self-Government.)

**Public Health Department**

*Director:* Major Jafar, I.N.S. (*officiating*); Lieut.-Col. A. C. Chatterjee, M.B.Cal., D.P.H.Camb. (*reverted temporarily to military duties*).

**Medical Department**

*Surgeon-General to the Governor of Bengal:* Maj.-Gen. W. C. Paton, M.C., M.A., M.B., B.Ch.Ed., F.R.C.S.Ed., K.H.P., I.M.S.

*Inspector-General of Hospitals (Dacca):* Lieut.-Col. H. J. Curran, M.B., B.Ch., D.T.M. & H.

*Inspector-General of Prisons:* Lieut.-Col. Malik Anup Singh, M.B., I.M.S.

**BIHAR (Patna)**

*Governor:* His Excellency Sir Thomas George Rutherford, K.C.S.I., C.I.E., I.C.S.

**Public Health Department**

*Director:* Rai Bahadur Dr. B. P. Mazumdar.

**Medical Department**

*Inspector-General of Civil Hospitals:* Col. William Collis Spackman, M.B., B.S.Lond., M.R.C.S., L.R.C.P., F.R.C.S.Ed., F.R.C.O.G.Lond., V.H.S.

**BOMBAY (Bombay)**

*Governor and President-in-Council:* His Excellency the Rt. Hon. Sir John Colville, G.C.I.E., T.D.

**Public Health Department**

*Director for the Government of Bombay (Poona):* Kaikhosru Ardeshir Gandhi, M.B., B.S.Bom., D.P.H., D.T.M. & H.Lond., J.P.

**Medical Department**

*Surgeon-General with the Government of Bombay:* Maj.-Gen. R. H. Candy, C.I.E., K.H.S., M.B., B.S.Lond., M.R.C.S., L.R.C.P., I.M.S., J.P.

**BURMA (at Simla)**

*Governor:* His Excellency the Rt. Hon. Sir Reginald Hugh Dorman-Smith, G.B.E.

**Public Health Department**

*Director:* Major Thomas Johannes Davidson, M.B., B.Ch.Aberdeen,  
D.T.M. & H.Eng., D.P.H. Aberdeen, I.M.S.

**Medical Department**

*Inspector-General of Civil Hospitals (Burma):* Col. Maurice Lawrence  
Treston, C.B.E., F.R.C.O.G., F.R.C.S., M.R.C.S., L.R.C.P., I.M.S.

**CENTRAL PROVINCES AND BERAR (Nagpur)**

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I.C.S.

*Deputy-Secretary to the Government, Local Self-Government, Medical and  
Public Health Departments:* Kavassari Narayana Subramanian,  
M.A.Mad., I.C.S.

**Public Health Department**

*Director:* Ramlal Tuli, M.B., B.S., D.P.H., D.T.M., L.M.

**Medical Department**

*Inspector-General of Civil Hospitals:* A. H. Harty, C.I.E., M.B., Q.U.  
Canada, M.R.C.S., V.H.S.

**MADRAS (Madras)**

*Governor and President-in-Council:* His Excellency Capt. the Hon. Arthur  
Oswald James Hope, G.C.I.E., M.C.

*Temporary Deputy-Secretary (Education and Public Health Departments):*  
C. O. Coorey, I.C.S.

**Public Health Department**

*Acting Director:* Rai Bahadur Dr. R. Adishesan, B.Sc., L.M.S.Camb.,  
Dip. Hyg.

**Medical Department**

*Suregon-General with the Government of Madras:* Maj.-Gen. G. Stott, C.I.E.,  
O.B.S., K.H.S., I.M.S.

**NORTH-WEST FRONTIER PROVINCE (Peshawar)**

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O.B.E.

**Public Health Department**

*Director:* Col. J. P. Huban, O.B.E., I.M.S.

**Medical Department**

*Inspector-General of Civil Hospitals:* Lieut.-Col. P. H. S. Smith, O.B.E.,  
I.M.S.

**ORISSA (Cuttack)**

*Governor:* His Excellency Sir William Hawthorne Lewis, M.A.Cantab., K.C.S.I., K.C.I.E., I.C.S., J.P.

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**Public Health and Medical Departments**

*Director of Health and Inspector-General of Prisons:* Lieut.-Col. A. N. Chopra, M.B., B.S., D.T.M.Liv., D.P.H.Eng., I.M.S.

**PUNJAB (Lahore)**

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*Secretary, Medical and Local Government Departments:* E. A. R. Eustace, O.B.E., I.C.S.

**Public Health Department**

*Director:* Khan Bahadur Dr. Abdul Hamid Butt, M.B., B.S.Pb., D.P.H.Lond., D.T.M. & H.Eng.

**Medical Department**

*Inspector-General of Civil Hospitals (Lahore):* Lieut.-Col. D. Clyde, C.I.E., M.D.Glas., D.P.H.Eng., I.M.S.

**SIND (Karachi)**

*Governor:* His Excellency Sir Hugh Dow, K.C.S.I., C.I.E., I.C.S.

*Minister-in-Charge of the Medical and Public Health, Veterinary, Civil Defence and Air Raid Precautions and Industries:* The Hon. Dr. Hemandas Rupchand Wadhvani, M.L.A.

**Public Health Department**

*Director:* O. M. Akbani, M.B., B.S.Bom., D.P.H.Lond., J.P.

**Medical Department**

*Inspector-General of Civil Hospitals:* J. E. Gray, I.M.S.

**UNITED PROVINCES (Allahabad)**

*Governor:* His Excellency Sir Maurice Garnier Hallett, G.C.I.E., K.C.S.I., I.C.S.

*Adviser to the Governor on Education, Industries, Local Self-Government and Public Health:* Dr. Panna Lal, M.A., B.Sc., LL.B.Cantab., D.Litt.Agra. Barrister-at-law, C.S.I., C.I.E., I.C.S.

**Public Health Department**

*Director, U.P. (Lucknow):* Rai Bahadur Anil Chandra Banerjea, M.B., B.S.Alld., D.R.P.H.(U.S.A.), C.I.E.

**Medical Department**

*Inspector-General of Civil Hospitals:* Col. Norman Briggs, M.R.C.S., D.P.H.Eng., I.M.S.



# New Zealand

## OFFICE OF THE HIGH COMMISSIONER

415, Strand, London, W.C.2. Telephone: Temple Bar 3241.

*High Commissioner:* W. J. Jordan.

## NEW ZEALAND GOVERNMENT

Wellington, New Zealand.

*Prime Minister:* The Rt. Hon. Peter Fraser, P.C., M.P.

*Minister of Health:* The Hon. A. H. Nordmeyer, B.A., Dip.Soc.Sc., M.P.

*Minister of Education:* The Hon. H. G. R. Mason, M.A., LL.B., M.P.

## HEALTH DEPARTMENT

Wellington

*Director-General of Health:* M. H. Watt, M.D., D.P.H. (N.Z.).

*Director, Division of School Hygiene:* H. B. Turbott, M.B., Ch.B., D.P.H. (N.Z.).

*Director, Division of Hospitals:* L. C. McNickle, B.A., M.D., Ch.B.(N.Z.).

*Director, Division of Public Hygiene:* F. S. Maclean, B.A., M.B., Ch.B. Cantab., M.R.C.S.Eng., L.R.C.P.Lond., D.P.H.(N.Z.).

*Director, Division of Dental Hygiene:* J. L. Saunders, B.D.S.(N.Z.).

*Principal, Dental Training School and Assistant Director (Training):* J. B. Bibby, D.D.S.Penn., B.A., Dip.Soc.Sc.

*Nutritionist:* Miss M. Bell, M.D., Ch.B.(N.Z.).

*Director, Division of Nursing:* Miss M. I. Lambie, N.Z.R.N., N.Z.R.M.

*Secretary:* A. O. von Keisenberg.

*Chief Clerk and Secretary to Board of Health:* C. J. Drake.

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**Auckland:** T. J. F. Hughes, M.B., Ch.B.Ed., D.P.H.Cantab.; G. O. L. Dempster, M.B., Ch.B., D.P.H.(N.Z.).

**Wellington:** H. Smith, M.A., M.D., Ch.B.Cantab., M.R.C.S.Eng., L.R.C.P., D.P.H.Lond.

**Christchurch:** T. F. Telford, B.A., Ch.B., B.A.O., M.D., Dip. in State Med. Dub.; J. H. Blakelock, M.Sc., M.B., Ch.B., D.P.H.

**Palmerston North:** D. Cook, M.D., M.R.C.P.Ed., D.P.H.(N.Z.).

**Hamilton:** L. S. Davis, M.B., Ch.B., D.P.H.(N.Z.).

**Invercargill:** K. J. H. Davies, L.M.S.S.A.Lond., D.P.H.

**Whangarei:** C. W. Dixon, M.D.Lond., D.L.O., D.C.H., D.P.H.

**Gisborne:** T. C. Lonie, M.B., Ch.B.Glas., D.P.H.Lond.

**New Plymouth:** J. F. Dawson, M.B., Ch.B., B.A.O., D.P.H.Irel.

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*Members:* C. R. Burns, M.D., Ch.B.(N.Z.), F.R.C.P.Lond.; J. Cairney, M.D., Ch.B.(N.Z.); P. S. Foster, M.B., Ch.B.(N.Z.), F.R.C.S.Eng.; C. E. Hercus, O.B.E., D.S.O., M.D., Ch.B.(N.Z.), F.R.A.C.P.; G. D. Robb, M.D., Ch.M.(N.Z.), F.R.C.S.Eng., L.R.C.P.Lond.; M. H. Watt, C.B.E., M.D., Ch.B., D.P.H.(N.Z.).

*Secretary:* C. J. Drake.

**ST. JOHN AMBULANCE BRIGADE OVERSEAS**

102, Jeffery Street, Anderson's Bay, Dunedin.

*Chief Commissioner for New Zealand:* Col. G. Barclay, O.B.E., K.St.J., V.D.

**MENTAL HOSPITALS**

*Director-General:* Theo. G. Gray, C.M.G., M.B., Ch.B., M.P.C.

**EDUCATION DEPARTMENT**

Wellington

*Director of Education:* C. E. Beeby, M.A., Ph.D.

*Superintendent, Physical Education:* P. A. Smithells, M.A.Cantab.

*Director, Child Welfare Branch:* J. R. McClune.

**South Africa****OFFICE OF THE HIGH COMMISSIONER**

South Africa House, Trafalgar Square, London, W.C.2. Telephone: Whitehall 4488.

*High Commissioner:* G. Heaton Nicholls.

*Secretary:* E. K. Scallan.

**GOVERNMENT OF THE UNION OF SOUTH AFRICA**

Pretoria, South Africa.

*Minister of Welfare and Demobilisation:* The Hon. H. G. Lawrence.

**COUNCIL OF PUBLIC HEALTH**

*Chairman:* The Minister.

*Deputy-Chairman:* The Secretary and Chief Health Officer.

*Members:* The Director of Veterinary Service; Mrs. J. E. Conradie; Senator W. J. O'Brien; R. H. Buchanan; Dr. K. Bremer, M.P.; Dr. C. P. Theron; Dr. E. H. Cluver.

**DEPARTMENT OF PUBLIC HEALTH**

*Secretary and Chief Health Officer:* Dr. Peter Allan.

*Deputy-Chief Health Officer:* Dr. A. J. van der Spuy.

*Commissioner of Mental Hygiene:* Dr. W. Russell.

*Departmental Chief Clerk:* N. A. G. Reeler.

**DETACHED OFFICERS****Cape Town***Deputy-Chief Health Officer:* Dr. H. S. Gear.*Assistant Health Officer:* Dr. J. J. du Pré le Roux.**Durban***Deputy-Chief Health Officer:* Dr. F. W. P. Cluver.*Assistant Health Officer:* Dr. A. L. Ferguson.**Johannesburg***Senior Assistant Health Officer:* Dr. B. M. Clark.**South African Railways and Harbours***Deputy-Chief Health Officer:* Dr. C. G. Booker.**INSPECTION AND SPECIAL STAFF***Assistant Health Officer:* Dr. P. C. Eagle.*Assistant Health Officer (Venereal Diseases):* Dr. N. L. Murray.*Medical Inspector:* Vacant.*Dental Health Officer:* Dr. T. Ockerse.*Nutrition Officer:* Dr. J. M. Latsky.*Medical Inspector (Cape Native Territories):* Dr. R. J. Smit.*Medical Officers (Native Health Units):* Dr. S. L. Karkand ; Dr. E. C. A. Fristedt.*Senior Dietitian:* Miss G. M. Sedgwick.*Encologist and Chief Rodent Officer:* D. H. S. Davis.**MATERNITY AND CHILD WELFARE***Medical Inspector:* Dr. K. D. Winterton.**PATHOLOGICAL AND BIOLOGICAL CONTROL  
LABORATORIES**

Cape Town and Vaccine Institute, Rosebank.

Cape Town Biological Control Laboratory.

South African Institute for Medical Research, Johannesburg, Port Elizabeth and Bloemfontein.

East London and Border Pathological Laboratory.

**PORT HEALTH OFFICERS****Cape Town :** Dr. J. M. Bosman.**Durban :** Dr. J. McKay.**Port Elizabeth :** Dr. H. W. A. Kay.**East London:** Dr. R. V. S. Stevenson.**Simonstown :** Dr. A. B. Bull.**Knysna :** Vacant.**Mossel Bay :** Dr. J. J. van Reenen.**Port St. Johns :** Dr. G. H. Meiring.**Saldanha Bay :** Dr. J. Rauch.**LEPROSY****Leprosy Advisory Committee***Secretary and Chief Health Officer:* Dr. Peter Allan.*Chairman:* Professor W. H. Craib.*Members:* Dr. A. Pyper ; Dr. A. J. Orenstein ; Dr. W. F. Rhodes ; Dr. E. H. Cluver ; Dr. K. Bremer, M.P.

**Institutions**

*Pretoria:* Dr. A. R. Davison ; Dr. H. J. F. Wood ; Dr. P. A. D. Winter.

*Emjanyana:* F. J. Roach ; Dr. P. A. Thornton.

*Mkambati:* J. P. J. Kolver ; Dr. F. S. Drewe.

*Amatikulu:* E. G. C. Scotney ; Dr. E. L. Riemer.

*Bochem:* J. H. Franz.

**Venereal Diseases****Venereal Diseases Advisory Committee**

*Secretary and Chief Health Officer:* Dr. Peter Allan.

*Chairman:* Dr. H. Gluckman, M.P.

*Members:* Departmental Medical Officers.

**Institutions**

Rietfontein (Johannesburg) : Dr. J. H. Loots ; Dr. J. Meyer ; Dr. N. Saks.

King William's Town.\* Bochem (Jane Furse) Memorial Hospital.\*

Elim Memorial Hospital.\*

**Malaria****Transvaal**

*Senior Malaria Officer:* Dr. S. Annecke.

**Natal**

*Medical Inspector:* Dr. C. A. M. Murray.

**TUBERCULOSIS**

\*Nelspoort Sanatorium : Dr. H. R. Ackermann ; Dr. P. Scher ; Dr.

C. A. Sleggs. King George V Hospital : Dr. B. A. Dormer ; Dr. J.

Friedlander ; Dr. F. J. Wiles. Rietfontein Hospital.

\* In addition to these Institutions under the direct control of the Department, there is a number of other hospitals where accommodation is available.

**PROVINCIAL OFFICIALS**

NOTE : *Municipalities appoint their own Medical Officers of Health.*

**Chief Medical Inspectors of Schools**

Orange Free State : Dr. Jansen van Vuuren.

Cape Province : Dr. L. Cilliers.

Natal : Dr. F. Z. van der Merwe.

Transvaal : Dr. J. A. Kieser.

**Director of Peri-Urban Areas**

‡Transvaal : Dr. J. Murray.

‡ This post covers those areas not controlled by a Medical Officer of Health.

**SOUTH WEST AFRICA OFFICIALS**

*Medical Officer to Administration:* Dr. B. Y. Vivier.

*Full-Time District Surgeon, Ovamboland:* Dr. W. Campbell.

*Medical Inspector of Schools:* Dr. J. E. Fischer.

**Southern Rhodesia****OFFICE OF HIGH COMMISSIONER**

Rhodesia House, 429, Strand, London, W.C.2.

Telephone : Temple Bar 1133.

*Acting High Commissioner:* E. C. F. Whitehead, O.B.E.

**PUBLIC HEALTH DEPARTMENT**

Head Office : Salisbury, Southern Rhodesia.

*Medical Director and Director of Medical Services, Military Forces:* Dr. A. P. Martin.

*Assistant Director of Medical Services, Military Forces:* Dr. G. R. Ross.

*Supervisor of Hospitals:* W. F. Wynne.

*Assistant Health Officer:* Dr. E. Baker Jones.

*Senior Dental Surgeon:* R. Woodcock.

*Schools Medical Officers:* Dr. T. G. Osler; Dr. A. Clark.

*Staff Matron:* Miss F. Pettigrew.

*Health Inspector:* H. V. Venables.

**PUBLIC HEALTH LABORATORY AND PASTEUR INSTITUTE**

*Director:* Dr. G. R. Ross.

*Acting Director:* Dr. B. P. Berney.

*Government Pathologist:* D. M. Gelfand.

*Senior Technical Assistant:* W. D. Alves.

**British Guiana****Georgetown, British Guiana**

*Director of Medical Services and Chairman (ex-officio), Central Board of Health:* H. B. Hetherington, O.B.E., M.C.P. & S.Ont., M.B.Tor.

*Director of Education:* L. G. Crease, M.A.Oxon, M.R.S.T.

**British Honduras****Belize, British Honduras**

*Senior Medical Officer:* The Hon. V. F. Anderson, M.D.Lond., M.B., B.S., M.R.C.S., L.R.C.P., D.P.H., D.T.M.

*Director of Education:* B. E. Carman, B.Sc., Dip. in Ped.

**West Indies****DEVELOPMENT AND WELFARE**

The Mooring, St. Michael's, Barbados.

*Comptroller:* Sir John S. Macpherson, K.C.M.G.

*Medical Adviser:* Sir R. Briercliffe, K.C.M.G., O.B.E., M.B., Ch.B., B.Sc., D.P.H.

*Social Welfare Adviser:* Miss Dora Ibberson.

**Bermuda****Hamilton, Bermuda**

*Chairman of Board of Health:* The Hon. H. J. Tucker, M.C.P.

*Resident Medical Officer, King Edward VII Memorial Hospital:* A. R. Butler, M.D., C.F.

*Senior Medical Officer:* H. C. Wilkinson, M.D.

*Superintendent, Mental Hospital:* A. O. Arton, M.D., C.M., D.P.H., F.A.C.S.

*Director of Education:* Major C. G. G. Gilbert, M.C., B.A.

## Bahamas

### Nassau, Bahamas

*Chairman of Board of Health and Acting Chief Medical Officer and Resident Surgeon:* L. W. Fitzmaurice, M.D., C.M., D.P.H., F.A.C.S., F.I.C.S., F.A.P.H.A., L.M.C.O., M.R.C.P. & S., M.R.San.I.

*Chairman of Board of Education:* The Hon. Sir O. B. Daly, M.B.E.

## Jamaica

### Kingstown, Jamaica

*President of Medical Council:* J. G. Moseley, M.R.C.S.Eng., L.R.C.P.Lond., M.B., Ch.B.Lond., M.D.Lond.

*Secretary:* G. P. F. Allen, M.B., B.S.Liverpool.

*Chairman of Central Board of Health:* Major T. J. Hallinan, C.B.E., M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.

*Secretary:* A. S. McCarthy.

*Director of Government Medical Services:* Major T. J. Hallinan, C.B.E., M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.

*Assistant Director:* J. M. Hall, M.B.E., M.R.C.S.Eng., L.R.C.P.Lond., C.P.H.

*Director of Education:* The Hon. B. H. M. Easter, C.M.G., C.B.E., B.A., M.L.C.

## TURKS AND CAICOS ISLANDS

*Medical Officer:* V. L. Tennant, B.M., Ch.B.Aberdeen.

## CAYMAN ISLANDS

*Government Medical Officer:* W. A. C. Hortor, M.R.C.S., L.R.C.P.

## Trinidad and Tobago

### Port-of-Spain, Trinidad

*Director of Medical Services:* Dr. George Maclean, O.B.E.

*Director of Education:* R. A. Patrick, M.A.

*Social Welfare Officer:* Miss Joyce Burnham, B.A. (Hons.).

## Barbados

### Bridgetown, Barbados

*President of General Board of Health:* E. B. Carter, M.D., C.M.McGill, L.M.S.Nova Scotia.

*Chief Medical Officer:* Dr. H. D. Weatherhead, M.R.C.S.Eng., L.R.C.P.Lond., D.T.M. & H.Eng.

*Director of Education:* H. Hayden, M.A.

## Leeward Islands

(Federated Presidencies : Antigua, St. Kitts-Nevis, Montserrat,  
Virgin Islands).

*Federal Senior Medical Officer:* C. N. Griffin, M.B.E., M.D., C.M.McGill,  
M.P.H. Johns Hopkins.

*Federal Education Officer:* A. C. G. Palmer.

### ANTIGUA

#### St. John's, Antigua

*Chairman of Medical Board and Medical Superintendent, Hospital, Asylums,  
etc.:* J. E. Wright, F.R.C.S.Edin., M.R.C.S.Eng., L.R.C.P.Lond.,  
L.D.S.Eng., R.C.S.

*Chairman of Board of Education:* His Hon. The Administrator, H. Boon,  
M.B.E.

### ST. KITTS-NEVIS

#### St. Kitts, Basseterre and Nevis, Charlestown

*Chief Medical Officer:* C. N. Griffin, M.B.E., M.D., C. M. McGill,  
M.P.H. Johns Hopkins.

*Chairman of Board of Education:* His Hon. The Administrator, J. D.  
Harford, C.M.G.

### MONTSERRAT

#### Plymouth, Montserrat

*Commissioner and Chairman of Boards of Health and Education:* His Hon.  
T. E. P. Baynes, O.B.E.

### VIRGIN ISLANDS

#### Road Town, Tortola

*Medical Officer:* R. H. Georges, L.R.C.P., L.R.C.S.

*Chairman of Board of Education:* His Hon. W. S. G. Barnes (Acting  
Commissioner).

## Windward Islands

### GRENADA

#### St. George's, Grenada

*Senior Medical Officer:* The Hon. E. Cochrane, M.D., M.B., Ch.B.Glas.,  
D.P.H.Lond.

*Chairman of Board of Education:* H. J. Padmore, M.R.S.T. (Education  
Officer), *ex-officio*.

### ST. LUCIA

#### Castries, St. Lucia

*Senior Medical Officer:* L. A. P. Slinger, M.B., B.Ch., M.R.C.S.Eng.,  
L.R.C.P.

*Chairman of Board of Education:* J. A. Rodway, B.A. (Inspector of  
Schools).

**ST. VINCENT****Kingstown, St. Vincent**

*Chief Medical and Health Officer:* W. Leslie Webb, M.B., B.S.Lond.,  
M.R.C.S.Lond., L.R.C.P.Eng., D.P.H. R.C.P.S.

*Chairman of Board of Education:* The Rev. H. N. Vincent Tonks.

**DOMINICA****Roseau, Dominica**

*Senior Medical Officer and Medical Officer of Health:* A. Scott-Gillett  
F.R.C.S.Edin., M.R.C.S., L.R.C.P.

*Education Officer:* H. V. Wiseman, B.A., B.Sc.

**United States of America (U.S.A.)****PUBLIC HEALTH SERVICE**

Temporary Building T-6, Bethesda, Md. Telephone: Oliver 4200.  
National Institute of Health, Bethesda, Md. Telephone: Wisconsin 7000.  
*Surgeon-General:* Dr. Thomas Parran.

*Deputy Surgeon General:* Dr. Warren F. Draper.

*Assistant Surgeon General, Director, National Institute of Health:* Dr. Rollo  
E. Dyer.

*Assistant Surgeon General, Chief, Bureau of State Services:* Dr. L. R.  
Thompson.

*Assistant Surgeon General, Associate Chief, Bureau of State Services:* Dr.  
C. L. Williams.

*Assistant Surgeon-General, Chief, Bureau of Medical Services:* Dr. R. C.  
Williams.

*Assistant Surgeon-General, Chief Medical Officer, War Shipping Adminis-  
tration:* Dr. Justin K. Fuller.

*Medical Director, Division of Commissioned Personnel:* Dr. W. F. Ossenfort.

*Dental Director, Division of Dentistry:* Dr. W. T. Wright, Jr.

*Sanitary Engineer-Director, Division of Engineering:* John K. Hoskins.

*Medical Director, United States Coast Guard:* Dr. Carl Michel.

*Chief, Division of Public Health Methods:* G. St. J. Perrott.

*Nurse Director, Division of Nurse Education:* Lucile Petry.

**Belgium****MINISTÈRE DE LA SANTÉ PUBLIQUE**

2, Place Royale, Bruxelles.

*Ministre:* Dr. Albert Marteaux (Member, Chambre des Représentants,  
Member, Commission d'Assistance Publique de Bruxelles).

**SECRÉTARIAT-GÉNÉRAL (ADMINISTRATIVE  
AND TECHNICAL DIRECTORATE)**

*Secrétaire-Général:* Dr. R. Sand (Professor, Université de Bruxelles, Hon.  
Member, Académie de Médecine).



*Secrétaire-Général (Acting):* Dr. Maurice de Laet (Professor, Université de Bruxelles, Corresponding Member, Académie de Médecine).

**Service l'Etudes et Service Juridique**

*Directeur:* M. Félix (Doctor of Law).

*Assistant:* Dr. Hougardy.

**Service du Personnel, de l'Economet et de la Comptabilité**

*Directeur:* M. Selvais.

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**L'Hygiène Publique**

*Directeur-Général:* Dr. van de Calseyde, assisted by doctors, pharmacists, engineers, veterinarians, chemists, visiting nurses, social workers and administrative services.

**La Médecine Sociale**

*Directeur-Général:* Dr. J. Goossens, assisted by doctors, inspectors, nurses and administrative services.

**L'Assistance**

*Directeur-Général:* M. J. Messinne (*at present Chief of the Cabinet of the Minister*) assisted by members of the legal profession, inspectors and social helpers.

**L'Education Physique, des Sports et des Oeuvres de Plein Air**

*Directeur-Général:* (Vacant.) Assisted by inspectors, technicians and doctors.

**Eire**

**OFFICE OF THE HIGH COMMISSIONER**

33-37, Regent Street, London, S.W.1. Telephone: Regent 4716.

*High Commissioner:* J. W. Dulanty, C.B., C.B.E.

**DEPARTMENT OF LOCAL GOVERNMENT  
AND PUBLIC HEALTH**

Dublin, Eire.

*Minister:* Sean MacEntee, T.D.

*Secretary:* J. Hurson.

**DEPARTMENT OF EDUCATION**

*Minister:* Thomas Derrig, T.D.

*Secretary:* Michael Breathnach, M.A.

**Primary Branch**

*Assistant Secretary:* Labhras O Muirthe, M.A., LL.B., B.L.

**Secondary Branch**

*Superintendent:* S. O. Gathain.

**Technical Instruction Branch**

*Chief Inspector:* Proinnseas O. Suilleabhain, Ph.D.

**Reformatory and Industrial Schools**

*Inspectors:* P. O. Muircheartagh; Dr. Anna M. E. McCabe.

# Netherlands

## MINISTRY OF SOCIAL AFFAIRS

Arlington House, London, W.1.

*Minister:* Ir. F. C. M. Wijffels.

## MINISTRY OF EDUCATION, ARTS AND SCIENCES

Arlington House, London, W.1.

*Minister:* G. Bolkesteijn.

## NETHERLANDS CHILDREN COMMITTEE

35, Eaton Square, London, S.W.1.

*Chairman:* P. Rykens.

## LONDON COMMITTEE OF THE NETHERLANDS RED CROSS

Arlington House, London, W.1.

*Chairman:* Th. de Meester.

## NETHERLANDS OFFICE FOR RELIEF AND REHABILITATION

Stratton House, London, W.1.

*Director:* N. A. de Gaay Fortman.

## NETHERLANDS WELFARE COMMISSION

Stratton House, London, W.1.

*Commissioner:* Lieut.-Col. Dr. A. M. Meerloo.

## H.A.R.K. RELIEF IN LIBERATED HOLLAND

*Food Department, Markt, Eindhoven:* M. de Vlam.

*Clothing Department, Baronielaan 120, Breda:* S. J. Jacobs.

# Union of Soviet Socialist Republics (U.S.S.R.)

*People's Commissar for Health Service:* G. A. Miterev, 3, Rachmanovski  
Pereulok, Moscow.

*For Scheme of  
HEALTH SERVICES  
see following page.*



## Sweden

### MINISTRY OF SOCIAL AFFAIRS

Kanslihuset, Stockholm.

*Minister:* Gustav Möller.

### SOCIAL BOARD

Birger Jarls Torg 2, Stockholm.

*Director-General:* Thorwald Bergquist.

*Acting Director-General during Mr. Bergquist's term as Minister of Justice:*

Karl Johan Höjer.

*Head of Department for Poor Relief and Chief Inspector of Poor Relief and Children's Care:* Ali Berggren.

### MEDICAL BOARD

Vallingaten 2, Stockholm.

*Director-General:* Dr. Axel Höjer.

*Head of Hospitals Department:* Dr. Lars Edén.

*Head of Medical Department:* Dr. Johan Byttner.

*Head of Mental-Care Department:* Dr. Peder Björck.

*Head of Public Health Department:* Dr. Ragnar Huss.

*Chief Inspector of Mental-Care:* Dr. Erik Goldkuhl.

### STATE INSTITUTE FOR NATIONAL HYGIENE

*Head:* Professor Ernst Abramson.

### EDUCATION BOARD

*Chief Officer of Health of Schools:* Dr. Carl Wilhelm Herlitz.

### DELEGATION FOR INTERNATIONAL CO-OPERATION IN SOCIAL POLICY

*Chairman:* Dr. Wilhelm Björck.

## International Labour Office (I.L.O.)

3480, University Street, Montreal, Canada.

*Acting Director:* E. J. Phelan (Eire).

*Assistant Directors:* Lindsay Rogers (America); Jef Rens (Belgium).

### INTERNATIONAL LABOUR OFFICE

Geneva, Switzerland.

### INTERNATIONAL LABOUR OFFICE

38-39, Parliament Street, London, S.W.1. Telephone: Whitehall 1437.

*General Relations Officer:* Clifton Robbins.

# United Nations Relief and Rehabilitation Administration (UNRRA)

Headquarters : Dupont Circle Building, Washington, D.C.

## THE COUNCIL

*Members:* Representatives of Australia, Belgium, Bolivia, Brazil, Canada, Chile, China, Colombia, Costa Rica, Cuba, Czechoslovakia, Dominican Republic, Ecuador, Egypt, El Salvador, Ethiopia, Provisional Government of the French Republic, Greece, Guatemala, Haiti, Honduras, Iceland, India, Iran, Iraq, Liberia, Luxembourg, Mexico, Netherlands, New Zealand, Nicaragua, Norway, Panama, Paraguay, Peru, Philippine Commonwealth, Poland, Union of South Africa, Union of Soviet Socialist Republics, United Kingdom, United States, Uruguay, Venezuela, Yugoslavia.

## COMMITTEES OF THE COUNCIL

### Central Committee

*Chairman:* Herbert H. Lehman.

*Secretary (pro tem.):* Luther Gulick.

*Members:* China : Tingfu F. Tsiang ; Union of Soviet Socialist Republics : V. A. Sergeev ; Vlas Andreevich Klentsov (Acting) ; United Kingdom : Richard Law, Ben Smith (alt.) ; United States : Dean Acheson.

### Committee of the Council for Europe

European Regional Office: 11, Portland Place, London, W.1. Telephone : Langham 3090.

*Chairman:* Ernest Brown (U.K.).

*Secretary (pro tem.):* A. A. Adams.

*Members:* Belgium : Raoul Richard. Brazil : Jose Cochrane de Alencar. Canada : Frederic Hudd. Czechoslovakia : Frantisek Nemec, F. Vondrich (alt.). Provisional Government of the French Republic : R. Massigli, P. Rauzan (alt.). Greece : Kyriakos Varvaressos, George Mantzavinos (alt.). Iceland : Magnus Sigurdsson, Stefan Thorvardsson (alt.). Luxembourg : Pierre Dupong, Victor Bodson (alt.), A. J. Clasen (temporary alt.), A. Als (temporary alt.). Netherlands : Arnold Th. Lamping, J. H. Zeeman (alt.). Norway : Anders Frihagen ; Christopher F. Smith (alt.). Poland : Jan Kwapinski, Tadeusz Lychowski (alt.), Ludwik Grosfeld (alt.). Union of Soviet Socialist Republics : Ivan Arsenevich Ilyuschenko. United Kingdom : Sir George Rendel. United States : John G. Winant, E. F. Penrose (alt.). Yugoslavia : V. Ribar, J. Sutej (alt.).

Alt. : Alternate member.

## Official Statements

(See also Supplement.)

# Ministry of Health

*Whitehall, London, S.W.1. Telephone : Whitehall 4300.*

*Minister: The RT. HON. H. U. WILLINK, M.C., K.C., M.P.*

THE Ministry of Health is responsible for the general supervision of all matters relating to public health, including not only public health and sanitary services in the ordinary sense of the terms, but also housing and public assistance. The Ministry is also concerned with rating and valuation, certain aspects of the law of building, the audit of local authorities' accounts, and wide general and financial aspects of local government. Most of the services for which the Ministry is responsible are operated by local authorities.

The war emergency services for which the Ministry is responsible include the Evacuation Scheme, the Emergency Hospital Scheme, with its associated laboratories, the Emergency Blood Transfusion Service, the Civil Nursing Reserve, the care and re-housing of the homeless after raids, first-aid repair of damaged houses, burial of civilian war dead, billeting of transferred war-workers, the Civil Defence First-Aid Post and Ambulance Services, and the Emergency Public Health Laboratory Service.

The Minister has no jurisdiction in Scotland or Northern Ireland. In Wales, many of his functions are exercised through the Welsh Board of Health, with headquarters at Cardiff. The Minister is also responsible to Parliament for the work of the Board of Control in relation to lunacy and mental deficiency, and for the department of the Registrar-General. He is also a member of the Committee of the Privy Council, which is responsible for Medical Research.

The Ministry is concerned with important measures of post-war reconstruction. Two Housing Acts have already received the Royal Assent; legislation on national water policy and on a permanent commission for the review of local government boundaries has been submitted to Parliament; and proposals for a national health service have been published in a White Paper.

The responsibilities of the Ministry of Health in relation to National Health Insurance (except medical benefit), contributory pensions and supplementary pensions, have been transferred to the Ministry of National Insurance. The Ministry of Health will have a joint responsibility with the new Ministry for a few matters, including dental benefit.

### Public Health Services

The public health services include maternity and child welfare, the control of infectious diseases, and the tuberculosis, cancer and venereal disease services. Protective services include supervision of the purity of food, drugs and therapeutic substances; water supply; sewerage and sewage disposal; refuse disposal; the provision of burial grounds and open spaces, and the enforcement of building and other bye-laws.

**Maternity and Child Welfare :** Through the major local authorities, extensive maternity and child welfare services are provided. At the end of 1943 there were 3,825 infant welfare centres in England and Wales, 1,939 ante-natal clinics and 893 post-natal clinics (these figures include a small proportion still run by voluntary associations). In addition to care at post-natal clinics, post-natal examinations are frequently made at the ante-natal clinics. The local authorities employ health visitors who, besides their work at the welfare centre clinics, visit the mothers in their homes after the birth of a baby and advise on the child's upbringing until it reaches the age of five and goes to school. During 1943 health visitors paid 4,519,091 visits to children between one and five years old, and 661,629 first visits to children under one year. This last figure represents 96·8 per cent. of the total registered live births.

As a wartime measure with the object of caring for the young children of women on war work, over 1,500 wartime day nurseries have been established by welfare authorities. The full cost of establishment and maintenance has been paid by the Ministry. To meet the needs of women on night shifts, some of the nurseries are open for 24 hours. Also, there are about 400 residential nurseries which are maintained under the Ministry's Evacuation Scheme and accommodate about 13,000 children under five.

Emergency maternity homes were also set up under this Scheme to enable mothers from evacuation areas to have their babies in peaceful surroundings; over 160,000 babies have been born in these homes since the outbreak of war.

The Ministry has collaborated with and advised the Ministry of Food in the distribution to mothers and young children of concentrated orange juice, national cod-liver oil compound and, for expectant mothers only, vitamin A and D tablets. These supplements are available at infant welfare centres and clinics—as well as at Food Offices and other recognised distribution centres—at a cheap rate, or free in cases of need.

**Infectious Diseases :** The Ministry is concerned with the supervision of the health services which are operated at sea and at airports by the Port Health Authorities, or appropriate local authorities, in order to safe-guard the country against the entry of infectious diseases. The Ministry also supervises the operation by local authorities generally, of the system requiring the compulsory notification of the more serious infectious diseases and the provision of isolation hospitals.

Since 1st January 1940, the Ministry and the local authorities have been carrying on a national campaign for the immunisation against diphtheria of children between one and fifteen years of age. At the end of 1944, more than half the child population had been immunised. Supplies of toxoid for the use of the local authority are provided free by the Government.

A campaign against the venereal diseases, which have become much more prevalent under war conditions, is also being carried out by the Ministry and the local authorities.

**Protective Services :** The personal health services are reinforced by the protective services, which include sewerage and sewage disposal, adequate water supplies, and the enforcement of legislation to ensure the purity of food, milk, drugs and therapeutic substances.

The Ministry is closely connected with matters relating to the nutrition of the people and acts as adviser to the Ministry of Food on the nutritional aspects of rationing. It also administers acts relating to the pasteurisation and cleanliness of milk.

**Nursing and Midwifery :** The war has seen the establishment, for the first time, of a special division in the Ministry of Health to deal with nursing and midwifery, to which the Minister looks for advice on matters regarding the two professions. This was set up in April 1941. During the war, there have been two other important permanent developments in the nursing and midwifery world ; the passage of the Nurses Acts of 1943 and 1945, and the establishment of the Nurses Salaries Committee and the Midwives Salaries Committee. Both these developments arose from recommendations made in 1938 by the Interdepartmental Committee on Nursing Services (the Athlone Committee).

The Nurses Acts placed upon the General Nursing Council (the body concerned with the framing of rules relating to the training of nurses for State-registration) the duty of forming and keeping a roll of assistant nurses and of framing rules relating to the training of assistant nurses. These rules are subject to the approval of the Minister, who has approved rules relating to the enrolment of existing assistant nurses and assistant nurses with intermediate qualifications, and has under consideration rules relating to the future training of assistant nurses. These provisions will secure for the assistant nurse a recognised status which she has not had hitherto.

The Acts also provide that from a date to be determined by the Minister, it will be an offence for persons other than State-registered nurses and enrolled assistant nurses, to use in relation to themselves any expression containing the word " nurse." An exception is made in favour of children's nurses and the Minister is empowered to make regulations authorising other classes of nurses to use expressions containing the word " nurse."

The Nurses Salaries Committee was set up in November 1941 and the Midwives Salaries Committee in May 1942. They are composed of employers and employees in equal numbers, under the independent chairmanship of the Rt. Hon. Lord Rushcliffe, G.B.E., to draw up agreed scales of salaries and emoluments for nurses and midwives respectively. The Nurses Salaries Committee has so far presented to the Minister three Reports on the salaries and emoluments of nurses, including one on mental nurses, drawn up by a special sub-committee. The Midwives Committee has presented one Report, covering the whole field within its purview. The Minister has accepted the recommendations and commended them to employing authorities, undertaking, pending the settlement of post-war health services, to meet half the additional cost of implementing them, provided they are adopted in their entirety. The recommendations have, in fact, been generally accepted and for the first time standard national scales are in operation throughout the country, reflecting for the most part a considerable improvement on the old varying scales. Both Committees remain in being to review their recommendations in the light of experience and many supplementary recommendations have been submitted to the Minister. (*See Section Officially-Appointed Committees*).

During the war, one of the greatest difficulties experienced in the staffing of the civilian health services has been the shortage of nurses and midwives,



mainly due to the increased demand for their services in the armed forces, emergency hospitals, and other casualty services, as well as to the counter demands for women in other forms of national service. Various steps have been taken to ease the position by the Minister of Labour and National Service, in consultation with the Minister of Health and on the advice of his National Advisory Council on the recruitment and distribution of nurses and midwives.

There was a registration of nurses and midwives in April 1943, and their employment has been made subject to various forms of control including, *e.g.* a requirement that newly qualified general State-registered nurses must spend their first year of service in one of a limited number of fields of special shortage, and that newly qualified midwives must practise midwifery for at least one year after qualification. The shortage still remains acute and the distribution uneven, and further measures are constantly under consideration.

**Civil Nursing Reserve :** As indicated in the section on nurses and midwives, the expansion of the hospital service and other medical services to meet wartime needs, demanded also expansion in nursing personnel.

In anticipation of such needs, the Civil Nursing Reserve was formed before the war. As it was desired to prevent nurses already engaged on essential nursing duties from giving up their duties, such nurses were not allowed to join the Reserve. Many of the early members were nurses who voluntarily returned from retirement to take up wartime duty.

Recruits for the Civil Nursing Reserve are in three grades : the trained nurse, who must be State-registered or on the list set up under Section 18 of the Nurses Act 1943 ; the assistant nurse who must be on the Roll of Assistant Nurses kept by the General Nursing Council for England and Wales ; and the nursing auxiliary who must pass a special short course of instruction, unless she has already completed such a course. To begin with courses of instruction are generally in two parts : (a) lectures and demonstrations in first-aid and home nursing, and (b) practical hospital work. But since April 1941 they have generally taken the form of an intensive fortnight's course in hospital. A large proportion of the nursing auxiliaries are members of the British Red Cross Society or the St. John Ambulance Brigade. About three-quarters of all the members of the Reserve are nursing auxiliaries.

In addition to hospital service, members are employed in casualty evacuation trains ; in the First-Aid Post Service, which includes mobile units and medical aid posts in air-raid shelters ; in rest-centres ; in medical services in reception areas under the Government Evacuation Scheme ; in wartime and residential nurseries ; on blood transfusion work ; and on any other work coming within the scope of the Reserve. Some of these services are now being largely disbanded, *e.g.* the First-Aid Post Service, and the number of members employed there now is small, but there has been a growing need for their services in hospital.

Conditions of service are laid down by the Ministry of Health. Members are employed by the authorities of the hospitals or other services to which they are allocated, who have to observe the general conditions of service laid down by the Ministry.

**Rates of Pay :** The First-Aid Post Service forms part of the Civil Defence (General) Services and members of the Civil Nursing Reserve employed whole-time in the First-Aid Post Service are, therefore, paid in accordance with the rates laid down for members of these services.

The rates of pay of members employed whole-time in all services other than the First-Aid Post Service are based on the national scales of salary recommended by the Nurses Salaries Committee.

Part-time members are not paid for their services, but if they are provided with a meal during duty hours, no charge is made for the meal, and where a hospital authority undertakes the laundering of a part-time member's uniform, no charge is made to the member.

#### MEMBERS EMPLOYED AT 31ST DECEMBER, 1944.

				<i>Whole-time</i>	<i>Part-time*</i>
Trained Nurses	..	..	..	3,052	376
Assistant Nurses	..	..	..	2,254	57
Nursing Auxiliaries	..	..	..	14,122	5,935

\*These figures do not include part-time members employed in hospitals, of whom there are probably about 5,000 of all grades.

**Welfare of the Blind :** In administering the Blind Persons Acts the local authorities have considerable discretion in determining what is required to make adequate provision for the blind, and the county or county borough boundaries, within which the authorities function, should leave no blind person, who is in need of assistance, uncared for.

Apart from education and training, which is the responsibility of local education authorities, the Blind Persons Act authorities have the duty of ensuring the welfare of blind persons of all ages, and to this end a specialist service of examination is available which entitles blind persons to be registered as eligible for the benefits provided in the particular areas in which they reside. Such benefits include arrangements for accommodating blind babies in Sunshine Homes, employment in workshops or home-workers schemes, domiciliary financial assistance, home teaching and visiting, the provision of homes for the aged blind and a considerable variety of social welfare services introduced on local initiative. The authorities may directly provide all or any of these services themselves or make use of the machinery of voluntary agencies acting on their behalf.

Apart from the compulsory notification and treatment of *ophthalmia neonatorum* for the checking of infantile blindness, local authorities are empowered to make such arrangements as they think desirable for the prevention of blindness and the treatment of those suffering from defective sight.

#### Public Assistance Services

Public assistance services provided by the local authorities include institutions for the needy, the care of destitute children, the lodging of vagrants, the care of the aged and infirm, and domiciliary assistance to destitute persons, including medical and dental assistance. The Ministry regulates the administration of relief on these lines. It maintains, for the purpose of control, a staff of inspectors.

#### Local Government

The great bulk of the services for which the Minister of Health is responsible to Parliament are administered by local authorities. In addition, local authorities are responsible for a number of services which come under Government departments other than the Ministry of Health, *e.g.* education is supervised by the Ministry of Education, the police services by the Home

Office, highways by the Ministry of Transport, and town and country planning by the Ministry of Town and Country Planning. The Ministry of Health is, however, the residuary department for all local government matters not specifically allocated to some other department. "Moreover, a local authority may not, except where Parliament has conferred special independent powers, borrow money or issue stock without the consent of the Minister of Health. This obligation upon local authorities ensures a large measure of central control of capital expenditure." Where powers to construct works and to borrow for the purpose are proposed to be conferred by local Act, the Minister reports to Parliament upon the Bill for the local Act, but, of course, it must rest with Parliament to decide whether the powers shall be granted. If the powers are allowed, the Minister ordinarily has no further responsibility."

All the accounts of the majority of local authorities and certain of the accounts of the remainder, are subject to audit by district auditors appointed by the Minister. They have the power, which ordinary professional auditors have not, to disallow any payment which is contrary to law or unreasonable, and to surcharge any sum disallowed or any loss or deficiency, upon the person responsible. Appeal against any such disallowance and surcharge lies to the High Court, or, when the amount involved does not exceed £500, either to the Court or to the Minister.

A local authority's expenditure on revenue account, unlike certain capital expenditure which involves borrowing, is not subject to direct control by the Ministry; nor is the valuation of property on which local rates are levied, nor the level of the rates themselves.

**Water Supply and Sewerage:** The Ministry of Health administers the Public Health Act provisions relating to water supply, sewerage and sewage disposal, and local authorities are executively responsible for sewerage work and for many of the water supply systems in the country. In addition there are statutory and private water companies. Before the war the Ministry had no jurisdiction over water undertakings not operating under the Public Health Act, unless a local Act so required, but during the war the Department has exercised licensing control over all works. The White Paper on *A National Water Policy* proposes that the Minister of Health should have greatly increased responsibility for water supply, and a duty "to promote the conservation and proper use of water resources and the provision of water supplies." In addition it is proposed that the Minister should have powers to require action where he has only been able to make suggestions in the past, e.g. the amalgamation of small undertakings, variation of limits of supply, taking and giving of bulk supplies, etc.

During the war, work of any kind has been strictly limited and there will be considerable arrears to be made up. Just before the war the Minister each year sanctioned loans by local authorities of approximately £4,500,000 for water supply and £6,500,000 for sewerage and sewage disposal. After the war, in addition to making up arrears of work, it is the Government's intention to secure better water supplies in rural areas, and the Minister will be responsible for administering the grant of £15,000,000 provided by the Rural Water Supplies and Sewerage Act, 1944.

During the war the Department watched the safe-guarding of water supplies, including precautions against sabotage.

### **Housing**

The Ministry of Health administers the Housing Acts and the Rent Restriction Acts. Parliament has given local authorities very wide powers and duties in the housing field. These include not only powers to build houses, but also to undertake slum clearance, to mitigate overcrowding and to see that landlords and owners keep their property in habitable repair. The main concern of local authorities is to maintain decent housing standards for the working classes. Of over 4,000,000 houses built between the two wars, local authorities were responsible for the construction of over 1,000,000. Up to 1939 the slums were being swept away at the rate of 60,000 dwellings a year.

The war brought house building to a standstill. Only a very small number of special housing schemes have been undertaken to meet urgent requirements connected with war production. The Ministry's policy has perforce been directed to finding ways and means of utilising existing accommodation to the best advantage. The problems of large movements of population, due mainly to evacuation and transfer of war-workers, have, in the main, been met by billeting or the requisitioning of houses. In addition nearly 40 areas have had to be closed to all except essential workers.

Local authorities have powers to requisition unoccupied houses for the use of certain priority classes, *viz.* bombed-out persons, evacuees and transferred war-workers. At the end of 1944, some 72,000 requisitioned houses were in use for these purposes. In August 1943 these powers of requisitioning were extended, to enable local authorities to deal generally with families inadequately housed; and at the end of 1944, a further 4,931 requisitioned houses were in use for this specific purpose. Another step to ease the position was the introduction of a scheme giving councils wide discretion in using available labour and materials on various types of building operations likely to permit the maximum use of existing buildings as dwellings. These operations cover war damage repairs, adaptation and conversion of properties into multiple family dwellings and ordinary maintenance work up to a specified limit of cost.

Legislative provision for post-war housing made during 1944 includes the Housing (Temporary Accommodation) Act, dealing with the temporary dwellings and the Housing (Financial Provisions) Act, which provides for subsidies for permanent dwellings built by local authorities.

### **War Emergency Services**

The Ministry is responsible for a number of special war services. These include evacuation of women and children from the most crowded areas; the provision of rest-centres, meals, clothing, information etc., for those who have been bombed out of their homes; first-aid repairs to houses damaged by enemy action; the rehousing of the homeless; billeting of transferred war-workers; ambulance services for air-raid casualties, and the provision of first-aid and hospital treatment for air-raid casualties in England and Wales; hospital treatment for Service sick and wounded in this country; the blood transfusion service; the Emergency Public Health Laboratory Service; the burial of civilian war dead and the organisation of the Civil Nursing Reserve.

The Ministry is also responsible for everything appertaining to the health and comfort of users of public air-raid shelters, including matters of public health such as infectious disease, vermin and sanitation, public order in the shelters, the construction and fitting of bunks, stoves and lighting appliances, and for ventilation.

**Evacuation :** An evacuation scheme was prepared by the Ministry of Health early in 1939, and put into action on the outbreak of war. Under this scheme about  $3\frac{1}{2}$  million women and children have been evacuated or re-evacuated from the London and other evacuation areas and housed in billets or hostels in the reception areas. Sick-bays were provided for the treatment of minor illnesses, and hostels were set up for children in need of special care, who were, for a time, unsuitable for billeting in private households. In January 1945 there were 236 hostels for children of difficult behaviour and 272 other hostels of various types. In some areas child-guidance services were established, or supplemented, to deal with special problems among evacuated children. Occupational clubs and social centres were set up in many places to provide interests for women obliged to leave their own homes. Over 100 emergency maternity homes have also been provided in safe areas, to which expectant mothers living in evacuation areas can go for the birth of their babies. There are also ante-natal and post-natal hostels, where mothers can stay before and after their confinements ; these are run in association with the maternity homes.

In the autumn of 1944, plans were set on foot to bring home evacuees to those areas which were then considered safe from enemy attack. These movements were completed by February 1945, except for those evacuees who had no homes to which to return.

**Rest-Centres :** To meet the needs of people obliged to leave their homes as the result of air-raids, about 22,000 first- and second-line rest-centres were prepared in the target and adjacent areas. These housed the bombed-out people until they could find other accommodation and provided them with meals and, if necessary, with clothing. Local authorities have also established 2,330 information and administrative centres where the homeless can get information and help.

In the autumn of 1944 the process of reducing the number of rest-centres and information services was begun in areas considered safe from enemy attack.

**Raid Homeless :** The Ministry is also responsible for ensuring that accommodation is found for families who have been made homeless by bombing, but are unable to make their own arrangements.

The total number of people actually rendered homeless is not known : but in the London Civil Defence Region alone, excluding those able to make private arrangements, about 786,000 persons have been assisted by local authorities—298,000 rehoused in requisitioned houses and 488,000 in billets.

**First-Aid Repairs :** Before the war broke out it was realised that one of the biggest problems would be repairs to damaged houses. Plans for speedy repairs, sufficient to make houses wind- and weather-proof, were drawn up, and local authorities, on the advice of the Ministry, laid in emergency stocks of building materials. When raiding began, the first-aid

repairs scheme was immediately put into operation. Over 4,000,000 houses in England and Wales have been damaged by bombs—more than one out of every three houses in the country. One million of these have been damaged in the flying-bomb attacks on “southern England.”

The 300,000 houses out of action include about 200,000 which were either demolished or are beyond repair. The remaining 100,000 have received temporary repairs. Under a special scheme initiated in 1943, work was speeded up on the repairs of badly damaged houses which could be made habitable with a reasonable expenditure of labour and materials. Intensive action is being taken in southern England to complete the repairs up to a standard of reasonable comfort.

**Emergency Hospital Scheme :** The wartime linking of hospitals to form an emergency service for dealing with war casualties, both Service and civilian, arose out of a survey, started in 1938, of the nation's hospital accommodation. A skeleton scheme was ready at the time of the “Munich” crisis in 1938, but it was further developed in the ensuing 12 months and put into action on the outbreak of war.

Basic principles of the scheme are that the hospital authorities remain responsible, under the scheme, for the treatment of injured persons, whether civilian or Service casualties and Service sick, while the Ministry has responsibility for organising existing facilities on a nation-wide scale and for finding additional accommodation and equipment where necessary.

At 31st March 1941, 80 per cent. of the 3,000 voluntary and municipal hospitals in England and Wales were within the scheme. Hospitals in danger areas act as casualty receiving hospitals and patients are, as quickly as practicable, transferred to base hospitals on the periphery or to country “branches.”

Extra accommodation was provided by “up-grading” existing units and by transforming public assistance institutions, mental hospitals and other suitable buildings into first-class hospitals. By this expansion, and by sending home sick persons fit to leave hospital, 190,000 beds were set free for casualties in the first week of September 1939.

In the absence of raiding this total was reduced, but an average of 140,000 to 150,000 empty beds were maintained up to the time of raids in September 1940.

Pre-war plans included the erection of new hutment hospitals. By this means over 40,000 beds have been added to the hospital services, either in the form of additional provision to existing hospitals or as self-contained, fully equipped hospital units, each unit comprising several hundred beds. By the end of 1940, 140 large private houses or similar buildings had been converted into hospital annexes, and 215 houses were available as convalescent units or “auxiliary hospitals.”

As reserve hospitals (for use if this country was invaded or swept by a widespread epidemic) suitable buildings such as boarding-schools or hostels were earmarked. By this means, about 70,000 additional beds were in readiness for emergency use.

The scope of the Emergency Hospital Scheme has continually widened. The primary intention was to accommodate raid casualties and any overflow of Service sick and wounded from Service hospitals. The term “E.M.S.” now applies to a wide category of patients, including Civil

Defence workers, members of the Women's Auxiliary Services, "transferred sick," evacuees, Merchant Navy personnel, members of the Women's Land Army and transferred war-workers.

In 1943 it was decided that on the invasion of Europe the E.M.S. should take the bulk of Service casualties direct from the battle-front, as an invasion operation obviously precluded the use of the usual system of casualty clearing stations and base hospitals behind the lines. For this purpose suitable coastal and near coastal hospitals were selected as "port" and "transit" hospitals, and other hospitals further inland were used as "home base" hospitals. Casualties were brought from the beaches and from the pre-fabricated port at Avranches, direct to the port and transit hospitals by sea and air and after any necessary treatment had been initiated or continued, were sent on, if fit to travel, to the base hospitals. Approximately 180,000 cases were dealt with in this way in the period, 6th June to 31st December 1944.

For this purpose civilian admissions to hospital were restricted from May 1944, until the late autumn of that year to those in immediate need of treatment, but it has now become possible to reduce considerably the beds reserved for E.M.S. cases and restrictions on the admission of civilian patients have now likewise been removed.

**Special Centres:** An important feature of the Emergency Hospital Scheme is the provision of facilities for specialised treatment. The old idea of a "general" hospital has given way to an inter-related system of hospitals each of which has been staffed and equipped to deal with specific diseases or injuries. Hospitals are classified according to the service or services in which they specialise, and the patient is sent to the one where he will receive the best treatment to meet his needs.

Special Treatment Centres have been attached to Emergency Hospitals throughout the country. To deal with fractures there are 22 orthopaedic centres with all the facilities necessary for the treatment and rehabilitation of the most complicated cases. These are supplemented by 83 fracture departments which are similar in conception but do not deal with the very difficult cases, and by over 300 fracture departments and clinics which handle the short-stay cases.

There are 26 special centres (usually associated with the orthopaedic centres) for peripheral nerve injuries, 9 special centres for neurosis, 1 for effort syndrome, 11 for chest injuries, 10 for head injuries, 9 for injuries of the spine, 12 for plastic surgery and jaw injuries, 3 for burns, 20 for skin diseases, 3 for selected Service rheumatic cases and 1 for trachoma.

In the reception areas, units for sick evacuated children have been established at 15 hospitals. Two radiotherapeutic centres for the treatment of cancer have been opened in the outer London area, because of the difficulty of providing irradiation at hospitals in inner London. There are also similar facilities at a number of provincial centres.

Mobile surgical teams, dental surgeries and laboratories and pathological laboratories are among other features of the Emergency Medical Services. The services of the Regional Dental Officers of the Ministry have been made available to assist in the expansion and co-ordination of dental services to meet essential wartime requirements.

**Blood Transfusion :** During the war, under the ægis of the Ministry, a Regional Blood Transfusion Service has been organised. In peacetime, hospitals relied on panels of donors arranged by voluntary bodies. In and around London the Medical Research Council, on behalf of the Ministry, has set up four blood supply depots. The Regional Service either co-ordinated or extended existing services, or inaugurated a supply service where none previously existed. Research has shown that two products of blood (plasma and serum) are reliable substitutes for whole blood. These products keep for some months without deterioration ; when dried after being frozen, they can be stored for years, sent to the far ends of the earth and quickly reconstituted with distilled water. A special drying plant was set up in 1943 which now has an output of over 2,500 bottles of blood a week. In 1943, 125,000 bottles were dried.

At the end of 1943, the Regional Transfusion Services and the London Blood Depots had about 938,000 names enrolled on their donor panels. The numbers of donors bled during 1943 was 450,000 ; of these 289,000 were bled by mobile teams sent to factories and outlying villages, etc.

In addition to meeting the needs of both civilian and Service hospitals and units in their own areas, the Emergency Blood Transfusion Services have made large contributions of blood and blood products for the use of the fighting forces overseas. During 1943, 18,000 bottles of blood products were sent to the Army, 23,000 to the Navy and 500 bottles to the Merchant Navy. At 31st December 1943, 399 stores of whole blood and 1,563 reserves of plasma or serum were being maintained, in addition to a number of stores of Rh negative blood which is of particular value for certain maternity cases.

**Civil Defence Ambulance Services and First-Aid :** The direct responsibility for adequate ambulance services and first-aid posts, set up to deal with air-raid casualties, rests with the local authorities, who include them in schemes which require the Minister's approval ; but direction in regard to detail comes from Whitehall.

In addition there was an extensive service to assist all those injured in air-raids ; it included ambulances for lying and sitting cases, gas cleansing centres, first-aid posts and points. All were adequately equipped and in charge of trained personnel. They were used for various peacetime purposes when not in use for their wartime duties.

With the changed war situation and limited enemy air-raid activity it was possible to make substantial reductions in these services during the closing months of 1944.

**Billeting of War-workers :** As a result of the expansion and dispersal of war industry, many thousands of workers have necessarily been transferred to employment in other districts. Some of these workers have been accommodated in hostels provided by the Production departments, but the majority have been lodged with private householders. In so far as they have been unable to make their own arrangements, the workers have been found lodgings (or where necessary billeted compulsorily) by the Billeting Officers of the local authorities, under general direction from the Ministry.



### WELSH BOARD OF HEALTH.

In Wales most of the health and allied services for which the Minister of Health is responsible are centrally administered through the Welsh Board of Health with headquarters at Cardiff. The Board was established in 1920 under powers conferred by the Ministry of Health Act 1919; and, although administratively linked with the Ministry of Health under a common Minister, in effect it constitutes a separate Government department for Wales.

The Board acts under the direction of the Minister of Health in the discharge of such functions as may be delegated to it from time to time. The transfer of functions has been gradual as the Board has gained in experience, and at the present time it has duties in relation to public health, poor law, housing, welfare of the blind and various local government services.

These duties have increased in variety as the result of various emergency measures taken by the Government under stress of war conditions. Coming within this category are the emergency hospital scheme, the evacuation, rest-centre and war-nursery services and the casualty services in the hands of the scheme-making authorities.

Under the Government's evacuation scheme the greater portion of Wales became pre-eminently a reception area. Some hundreds of thousands of persons from London and the other evacuation areas were accommodated under arrangements made by the Welsh Board and local authorities.

Welsh local authorities communicate direct with the Board at its offices in Cardiff and close contact is maintained with the authorities through visits. The Minister's Welsh department has thus wide and intimate knowledge of Welsh problems and of the special difficulties of the Principality. These difficulties were well-known before the war. In the mining districts of South Wales in particular the health, social and economic problems associated with the Special Areas existed in acute form. It is not so well-known, however, that the rural districts of Mid and North Wales shared in this economic depression. Agriculture declined and there was a large exodus of population from rural as well as industrial areas. More normal conditions are returning with the changes brought about by the war, but Wales remains a country of low rateable value and poor financial resources, which are not without influence in their relation to the problems of local government.

Wales in the industrial sense is a land of contrasts. Three-quarters of the population live in the areas on or near the South Wales coalfield, where coal-mining, largely for export, and metal manufacture are the principal industries. Somewhat similar industrial conditions are found in parts of north-east Wales. Much of the rest of the country consists of farm or uncultivated upland, with attractive holiday resorts and some fishing along the coast, and the means of livelihood are hard. The hilly nature of the country does not help towards easy communication; there are few towns of any size outside South Wales and the units of local government are for the most part small. These are factors which must be taken into account when considering the special problems of the Principality.

# Ministry of National Insurance

*Carlton House Terrace, London, S.W.1. Tel.: Whitehall 4341.*

*Minister: The RT. HON. SIR WILLIAM JOWITT, K.C., M.P.*

THE Ministry of National Insurance Act was passed in November 1944, and the Rt. Hon. Sir William Jowitt, K.C., M.P., was appointed the first Minister. Immediately afterwards the appointments of Sir Thomas Phillips, K.C.B., K.B.E., as Secretary, and Sir Thomas Sheepshanks, K.B.E., C.B., as Deputy Secretary, were announced, and a little later those of other principal officers in the department. At the beginning of February 1945, the Ministry was established in its London headquarters at 6, Carlton House Terrace, S.W.1.

Under the Act establishing the Ministry it is provided that there shall be transferred to the Ministry by Orders in Council, subject to the detailed provisions of the Act: (a) The functions of the Ministry of Health and of the Secretary of State for Scotland, with respect to national health insurance, widows', orphans' and old age pensions and supplementary pensions; (b) the functions of the Ministry of Labour and National Service with respect to unemployment insurance and unemployment assistance; and (c) the functions of the Home Secretary with respect to workmen's compensation.

The existing schemes thus transferred to the Ministry of National Insurance will be carried on as at present, and with the staff already engaged upon them, until the introduction of the new schemes foreshadowed in the White Paper on Social Insurance, Parts I and II (Cmd. 6550 and 6551).

For the purposes of the new schemes the Ministry will establish a network of local offices throughout the country to meet the convenience of the public. The bulk of the headquarters staff of the new Ministry will be housed at Newcastle-upon-Tyne, only the Minister and a comparatively small staff being located in London.

The duty of preparing legislation to give effect to the new proposals rests on the Ministry of National Insurance. The measures will include:

A Bill to introduce a scheme of family allowances. By this, allowances of 5s. a week are to be payable to families for each child except the first. The scheme will be universal and non-contributory.

A scheme of industrial injury insurance to replace the existing scheme of workmen's compensation. This scheme is to be contributory, contributions being paid by the worker, the employer and the Exchequer into a fund from which the benefits will be provided. The benefits will cover total and partial incapacity and also death. The payment for incapacity will be based on an assessment of the degree of disablement suffered, and in this respect the scheme will closely resemble the war pensions scheme for disabled soldiers and the scheme for civilian war injuries. The provisions of the existing Workmen's Compensation Acts will continue in force for cases that occur before the introduction of the new scheme.

A Bill to amend the existing schemes of health, pensions and unemployment insurance. This will make the amounts and conditions for the receipt of sickness and unemployment benefit as nearly as possible identical. It will bring substantial increases in the amounts paid in respect of sickness and maternity. The rates of old age pensions and the provision for widows will also be substantially improved, and the conditions for receipt of these pensions altered in some respects, notably in introducing a retirement condition for receipt of old age pension. It is also proposed to introduce a scheme of death grants. The normal amount payable in respect of the death of an adult will be £20, with lower rates for youths and children.

Other measures will be introduced to give effect to the proposal in the White Paper (Part I) for extension of the powers of the Assistance Board to include financial assistance to all on proof of need. This will involve the cessation of the present system of public assistance. The White Paper indicates that certain responsibilities, such as the care and maintenance of orphans and deserted children and the provision of accommodation for such old persons as need it, will remain with local authorities.

## Board of Admiralty

*Whitehall, London, S.W.1. Telephone : Whitehall 9000.*

*First Lord of the Admiralty:* The RT. HON. ALBERT VICTOR ALEXANDER, C.H., M.P.

BY the regulations and custom of the Royal Navy, commanding officers, divisional officers and senior ratings, and their equivalents in the Royal Marines and W.R.N.S., are directly responsible for all matters appertaining to the welfare of naval personnel.

At the Admiralty the welfare of the Navy is administered by the Second Sea Lord through his departments; throughout the Navy, officers with specialised knowledge are appointed to deal with such matters as pay, victualling, service accommodation, health, education, vocational training, resettlement advice, etc., but in addition to these provisions, a wide range of welfare services is available to naval personnel.

One of the most important of these welfare services is the Family Welfare Organisation. This consists of Family Welfare Sections established at the Manning Depots, and at some of the principal ports in the United Kingdom. The Sections are staffed by experienced and trained welfare workers including naval, W.R.N.S. and civilian personnel. Their duty is to give immediate and expert advice to any rating, or to the family or dependant of any rating, who requires help in solving a domestic or family problem. Advice can be given in personal interviews, or the commanding officer of any rating seeking advice or help, can send a Naval signal from any part of the world, in confidential code to a Family Welfare Section, requesting that the advice required be signalled back. These Sections work very closely with the Soldiers', Sailors' and Airmen's Families Association and other kindred organisations, especially in inland areas, and also with the Royal Naval Benevolent Trust.

This is the only fund caring exclusively for the benevolent requirements of all naval personnel below the rank of Warrant Officer who have served, or are serving in the Navy, and for their families and dependants.

Each of the principal Family Welfare Sections has a Legal Aid Section with an experienced and qualified Legal Aid Officer in charge.

Other important services are the provision of clubs, canteens and hostels by NAAFI, voluntary organisations and seamen's societies; live entertainment by NAAFI through ENSA; cinema entertainment by the Royal Naval Film Corporation; indoor and outdoor recreational equipment, comforts, grants and loans of money for recreational purposes by the Royal Naval War Amenities Fund, Royal Naval War Comforts Committee and the Royal Naval and Royal Marines Sports Control Board; and books for small ships by the Royal Naval War Libraries. Leave facilities can be arranged through the Naval Officers' Leave Bureau, the Incorporated Soldiers', Sailors' and Airmen's Help Society, and other organisations.

To ensure that Naval personnel enjoy the fullest use of these facilities, Welfare Services Officers are appointed to commands, ports, bases, air-stations and shore establishments throughout the world wherever the White Ensign is flown.

## Air Ministry

*Adastral House, Kingsway, London, W.2. Tel: Holborn 3434.*

*Secretary of State for Air: The RT. HON. SIR ARCHIBALD SINCLAIR, Bt., K.T., C.M.G., M.P.*

IN the Royal Air Force and the Women's Auxiliary Air Force, it is the duty of every officer to spare no effort to resolve the anxieties and to promote the contentment of the men under his command. It is not enough for officers to be good technicians and specialists; they must also be leaders of men. The officer who is content to be technically efficient *may* inspire respect; the good leader *will* inspire affection. The Air Council, therefore, calls upon all officers to give time and thought to these matters and to act constructively in the general interest.

The three main objectives of welfare in the R.A.F. are: The elimination of private worry from the minds of individuals so that they can give undivided attention to duty; the improvement of living conditions (accommodation, messing, clothing, duty travel, etc.) to the highest standard which regulations and wartime standards permit; and the provision of facilities for the use of leisure time so that not only are monotony and boredom averted, but the spirit, mind and physique are maintained, developed and "re-created."

The facilities available to assist officers to achieve these objectives are numerous and varied. Some are official, some semi-official; others are provided by voluntary organisations and individuals. Great stress is laid on officers' ability to adapt and improvise, and the importance of using local facilities is emphasised.

**R.A.F. Welfare Organisation :** The R.A.F. Welfare Organisation was established in March 1940. The Air Ministry Order announcing it, also gave particulars of the Directorate of Air Force Welfare, and of the arrangements for welfare desirable at stations. The order stressed : The responsibility of every commanding officer for welfare questions ; the necessity for station welfare co-ordinating committees to be set up ; and the necessity for co-operation between stations and local organisations, voluntary bodies and county welfare officers. The establishment of this welfare organisation did not, and never was intended to, relieve the individual officer of his responsibility for the welfare of the men under his command. Its object is to provide him with assistance in discharging that responsibility.

At the Air Ministry, the Director of Air Force Welfare is responsible to the Director-General of Personal Services in the Department of the Air Member for Personnel. The Director advises commands at home and overseas on all welfare matters and, in liaison with other directorates, Services, civilian organisations and individuals, he co-ordinates and develops welfare activity.

At commands, groups and stations, detailed organisation of specific activities may be sub-delegated, any specialised experience available being fully utilised.

Each R.A.F. station has a welfare co-ordinating committee composed of volunteers, which represents officers, airmen and airwomen, and the best person is selected to organise each activity regardless of rank. The Commanding Officer, as *ex-officio* president, nominates the chairman, who is usually the station administrative officer. The committee discusses and advises on questions of station welfare policy ; is responsible for welfare organisation and dates for recreational and entertainment events, etc. ; plans and publicises on the station a programme of welfare activities ; and ensures continuity, co-ordination and a voice for all.

The committees dealing with each recreational activity are represented on—and co-ordinated by—the welfare committee, *viz.*, sports, entertainments, library, savings, messing, etc.

There is also a station P.S.I. Committee which is composed of corporals, aircraftmen and aircraftwomen. It is under the chairmanship of the President of the Service Institute, appointed by the C.O., and its duties include supervision of the institute in the interests of airmen and airwomen, proposals for expenditure of institute funds, complaints and suggestions.

The R.A.F. Welfare Organisation co-operates very closely with the Admiralty and War Office Welfare authorities. Not only is liaison maintained at a high level through the Services Committee for the Welfare of the Forces, set up in 1941 to co-ordinate welfare arrangements affecting personnel of all Services, but at home the facilities of the Army Welfare Organisation are available to all R.A.F. personnel. Its County Welfare Officers are locally available to assist R.A.F. stations, units and personnel. They help by advising on and investigating domestic affairs ; provide local knowledge and contacts, *e.g.* in arranging local hospitality ; and disburse Treasury and other financial aid to small, isolated units, new stations and detachments.

**Finance :** There are various sources of finance available to stations for welfare purposes and, as due provision is made for pooling, it is possible for most welfare needs to be provided without assistance from public funds.

The main source is rebate paid by the Navy, Army and Air Force Institutes on purchases made from station NAAFI canteens. This rebate is paid into station P.S.I. funds, which are administered by the President of the Service Institute with the assistance of a committee of airmen and airwomen. Additional financial assistance is available from various sources for a variety of purposes, including provision of recreational libraries and sports gear, and many stations also have their own non-public incomes derived from the sale of garden produce, etc.

**Personal Problems :** Considerable importance is attached to the giving of advice to personnel in private difficulties. In addition to personal contact between officers and men, many station welfare committees have a personal advice panel consisting of volunteers whose abilities and experience specially fit them for this work. Whom to go to, where and at what time, for advice on private difficulties is publicised on stations. Close liaison is maintained with local Citizens' Advice Bureaux, and wherever possible, a voluntary legal adviser is available. A scheme is in existence under which legal aid is available to all personnel of the rank of sergeant and below, unable to afford fees. In the elimination of private worry, voluntary organisations play a vital part, and the closest contact exists between station welfare committees and such bodies as the R.A.F. Benevolent Fund, the Soldiers', Sailors' and Airmen's Help Society, the Soldiers', Sailors' and Airmen's Families' Association, etc.

In the constant effort made to improve living conditions, stress is laid on the importance of the Service Institute at each station and unit. This is the club for all ranks up to corporal and the raising of the standard of comfort in the institute is the constant concern of the P.S.I. and welfare committees.

The provision of comforts to the R.A.F. is the business of the R.A.F. Comforts Committee, which is a branch of the Directorate-General of Personal Services. The Committee provides to units at home and overseas a wide range of amenities from woollen garments to dance-band instruments.

**Use of Leisure Time :** The provision of facilities for the use of off-duty time calls for as wide a variety of recreations as possible, and the success of any activity is not judged by its mere popularity. The majority of personnel are most attracted by those activities calling for a minimum of effort on their part. But the most satisfying and constructive recreations are those demanding maximum effort. They usually attract enthusiastic minorities and are especially encouraged. The following recreations are common on R.A.F. stations :

**INDOORS.**—Games, gymnastics, boxing, fencing, roller-skating, discussion groups, brains trusts and quizzes, voluntary study, voluntary lectures, reading (libraries), production of wall-newspapers, radio-listening circles, handicrafts and model-making, sketch and art clubs, station concert parties, dramatic and choral societies, play-reading circles, dancing and dancing lessons, music clubs, voluntary bands as well as entertainment by outside performers, film entertainment, instructional and documentary films.

**OUTDOORS.**—Games, voluntary P.T., cycling, ice-skating, athletics, climbing, fishing, walking, riding, gardening, visits to places of interest, camera clubs, etc.

**Entertainment :** Every encouragement is given to station concert parties, dramatic societies, etc., and in providing facilities for these activities NAAFI/ENSA plays a very important part, as well as in the provision of shows performed by professional artistes. The development of constructive interest in drama and music on stations, however, has first priority in entertainment policy.

Cinema entertainment is also provided by ENSA both in the form of 35 mm. static cinemas, ENSA-operated, on stations of over a certain strength, and by mobile cinemas for small isolated units. Many R.A.F. stations own their own 35 mm. apparatus, purchased from P.S.I. funds, and provide film shows which are arranged and managed entirely by Service volunteers in their spare time. Similarly, voluntary bands receive the fullest encouragement. Handicrafts and gardening are encouraged with the object of enabling serving personnel to make the best use of their spare time.

**Physical Education and Recreation :** The conservation of robust health is of primary concern to all the fighting Services. The R.A.F. seeks to achieve this state of health, in its positive and active sense, by means of a comprehensive scheme of physical education. The policy is clearly outlined in the general aim : to obtain and maintain the highest standard of development and functioning of the body, and thereby to aid the development of mental capacity and character. To achieve this aim, the R.A.F. provides a large establishment of trained instructors, both men and women, whose duties are concerned with all aspects of physical training and recreation. In addition, selected instructors assist in the physical and mental rehabilitation at special centres and hospitals.

To cater for most diversified programmes of training, as well as voluntary tastes in recreation, there is a substantial provision of recreational facilities and equipment, which includes playing-fields, swimming-baths, gymnasia, and all kinds of gymnastic and sports material. The character of the physical training is determined by the needs of the men and women and their ultimate function of service. Particular attention is given to progressive physical training and recreation for air crews. In all branches of the work, there is close co-operation between the doctor and physical training instructor.

**Study and Education :** All personnel may, if they so desire, devote much of their spare time to serious study and reading. In order to help them, the services of an education officer are available on most stations, and reference libraries, evening classes and correspondence courses, are provided or arranged on the spot. They are also encouraged to attend classes at technical colleges and other institutions of the local education authorities, and are if necessary, assisted financially in doing so. Special leave is usually granted to enable them to take public examinations. Interest in current affairs is maintained by lectures given on the stations (principally by lecturers on the panels of the Regional Committees for Education in H.M. Forces) and wherever possible by organised discussion groups.

Music circles, art clubs, dramatic societies and similar activities of a purely cultural nature, are also fostered and developed on nearly all stations, and in this connection education officers are encouraged to avail themselves as much as possible of the facilities offered by the Council for the Encouragement of Music and the Arts.

# Ministry of Education

Belgrave Square, London, S.W.1. Tel. : Sloane 4522.

Minister: The RT. HON. R. A. BUTLER, M.P.

THE Ministry of Education has a direct responsibility for the health of school children in England and Wales through the School Medical Service, which is operated by the local education authorities. This provides for regular medical inspection and for the treatment of minor ailments, defective teeth and vision, and certain other types of defect. The central administration of this service is the responsibility of the Ministry's Medical Branch which operates in close co-operation with the Ministry of Health, whose Chief Medical Officer, Sir W. Wilson Jameson, also acts as Chief Medical Officer to the Ministry of Education.

Besides the prevention and cure of diseases there are other and more positive approaches to health which fall within the sphere of the Ministry. Although not directly controlling the curriculum in the schools, the Ministry influences it in three ways: By the advice given to teachers by H.M. Inspectors; by publications such as the *Handbook of Suggestions for Teachers*, *Health Education*, *The Syllabus of Physical Training* and *Sex Education*; and by its influence on the curriculum of training colleges for teachers.

In these ways the Ministry is able to exert an influence which permeates the work of all the schools. Health should not, in the Ministry's view, be regarded so much as a school subject (though much can be done, especially in the case of older children, through, for instance, good biology teaching) as an aspect of education which should be interwoven with the whole regime of school life. In this process hygienic school premises, games and physical training, with facilities for shower-baths and change of clothing, play an important part. School meals make a vital contribution, not only in ensuring adequate nutrition but in serving as a basis for sensible ideas about what and how to eat.

The Education Act 1944 will have far-reaching effects on the health of the school population. Besides securing a high standard of amenities in all types of school, the Act has extended the duties of local education authorities, so that as from 1st April 1945, it becomes obligatory on them to provide for the medical inspection of all children attending schools maintained from public funds, and to see that all those in need of treatment, other than domiciliary treatment, shall receive it without charge. By bringing in the young people who will attend county colleges (when they are established) on a part-time basis, this will secure medical supervision and treatment for all children and young people (except those attending independent schools) up to the age of 18. The county colleges and an expanded youth service, will provide further opportunities for education in the principles of healthy living.

Other provisions of the Act having a bearing on health, are the imposition of a duty on local education authorities to provide nursery education wherever it is needed, and the powers granted to education authorities to supply—or aid the supply of—clothing and footwear to children and young people attending grant-aided schools. The expansion of the school meals service, which the Government intends to provide free to parents as part of their plans for family allowances, will also make its contribution to this end.



# Ministry of Food

*Portman Square, London, W.1. Tel.: Welbeck 5500.*

*Minister:* COLONEL THE RT. HON. J. J. LLEWELLIN, C.B.E., M.C.,  
T.D., M.P.

THE primary task of the Ministry of Food is to provide everyone in the United Kingdom with enough to eat of the right kind of food. This involves procuring food in the right amounts, distributing it and controlling prices. In doing all this, the Ministry is necessarily drawn into a number of activities which, strictly speaking, come under the heading of social welfare and health education.

**Social Welfare Measures:** The subsidising of food prices so as to maintain them within the reach of all consumers is perhaps best looked upon as part of the general wartime policy of holding the cost of living. But the provision made by the Ministry of Food to meet the special nutritional needs of certain classes of the community may logically be regarded as a social welfare scheme.

The need of expectant and nursing mothers, infants, children, adolescents, invalids and industrial workers for food to supplement the domestic ration, has been recognised in various rationing or distribution arrangements. In the case of milk, "priority" classes have been established with entitlements to milk allowances considerably higher than the allowances made to the ordinary consumer. Milk is supplied to most "priority" consumers at the reduced price of 2d. a pint (or free, if their income is below a certain level), thereby ensuring that those entitled to the extra milk can actually afford to obtain it.

Similar arrangements are made for the issue of concentrated orange juice and fish-liver oil products. These are made available, under the Welfare Foods Scheme, at a small charge (or free in certain circumstances), to expectant mothers and children under five. The other needs of the expectant mother for extra nourishment can be met by using the ration book which she holds on behalf of her unborn child.

School feeding, which existed only on a limited scale before the war, has been rapidly expanded in wartime by the Ministry of Education as a means of supplementing the domestic rations of children of school age. The aim is to provide every schoolchild with a midday meal, and in pursuance of this aim the Ministry of Food has made its emergency cooking depôts in many areas available to supply cooked meals to schools. To ensure that it shall be a nutritious meal, the Ministry makes food allowances to school canteens on a special priority scale. Schoolchildren also receive a daily allowance of milk under the milk-in-schools scheme.

The need of the industrial worker for extra food has also been met through the encouragement of canteen feeding and of "British Restaurants." Food allowances to canteens catering for workers are on a more generous scale than those to other types of catering establishments. Special allocations are also made to miners' canteens, while a special ration of cheese is made available to certain isolated groups of workers who cannot avail themselves of communal feeding facilities (*e.g.* agricultural and forestry workers,

etc.). Invalids suffering from specified complaints can obtain extra rations of certain foods on a doctor's certificate.

**Food Education :** The war has made considerable changes in the kinds and qualities of food available for consumption in Britain. At the same time it has become more than ever important to get the maximum value out of the food. These two factors together have led the Ministry of Food to undertake, in collaboration with the Ministry of Education, an extensive campaign of food education. The aim of this campaign has been twofold : (a) To help the housewife cope with day-to-day changes in supply, by giving her recipes for making attractive dishes with the foods that are available ; (b) to educate people in the more fundamental matter of the selection of a healthy diet. This involves persuading them to eat more vegetables, to cook them properly, and so on.

Machinery has had to be created for the conduct of the campaign. Use has been made of press advertising (*Food Facts*) on a scale never undertaken before by a Government department. Posters and leaflets have been issued. The radio and the films have also been used as a medium for Ministry of Food publicity. Both the *Kitchen Front* broadcasts and the short *Food Flash* films have firmly entrenched themselves in public favour.

Direct contact with the housewife and her problems has also been established by the Ministry of Food. Food Advice Centres have been opened in a number of towns throughout the country, where housewives can attend lectures and demonstrations and ask for advice, leaflets, etc. For schools a special service has been organised through the circulation of a monthly *Domestic Science Bulletin* containing information calculated to help and interest domestic science teachers and their pupils.

**Food Standards :** In addition to trying to teach people what they should eat for good health, the Ministry of Food exercises control in a number of ways over the quality of food available for consumption. It has laid down quality standards for certain foods, e.g., margarine, flour and bread, sausages, preserves, etc. Periodic tests are made to ensure that these standards are properly observed. Thus margarine and cod-liver oil are tested for vitamins A and D, and concentrated fruit juice for vitamin C, while large numbers of samples of national flour and bread are analysed and reported on for quality.

The Ministry has also organised a regular survey of the quality of meals served at canteens. The survey results enable administrative action to be taken where necessary to improve the nutritional value of the food served, as well as providing much useful information to guide the future policy of the Ministry.

Thanks to the introduction of a system of licensing, the manufacture and sale of a food substitute purporting to possess the nutritive properties of some other food is now rigidly controlled. When the Ministry issues a licence in respect of a food substitute, it lays down conditions governing the price, trade-name and advertising claims of the product.

A new development likely to have far-reaching effects is the making of the Defence (Sale of Food) Regulations on 28th October 1943. These regulations provide penalties for the use of labels or advertisements which falsely describe any food, or which mislead the purchaser as to its nature, substance, quality or nutritional or dietary value. They also empower the Ministry to lay down food standards.

**Application of Science to the Problems of Food Control:** In all its activities, the Ministry of Food makes full use of scientific knowledge and advice. The Ministry has its own Scientific Adviser, Sir Jack Drummond, D.Sc., F.I.C. (formerly Professor of Biochemistry in the University of London). He is responsible for advising the Minister of Food on the scientific aspects of all food problems, organising research where necessary, and maintaining contact with nutritional and other scientific research organisations.

The Minister of Food is advised on the medical aspects of food problems by Lord Horder.

## Ministry of Fuel and Power

*7, Millbank, London, S.W.1. Telephone: Abbey 7000.*

*Minister:* MAJOR THE RT. HON. GWILYM LLOYD GEORGE, M.P.

THE first Medical Inspector of Mines was appointed in 1927, but it was not until 1943 that the Mines Medical Service as now constituted came into being. The Service owed its origin to the Government White Paper on Coal, of June 1942. Its personnel consists of one Mines Medical Officer in each of the eight main coal-producing regions, with a Chief Mines Medical Officer and his deputy at the headquarters in London.

Apart from certain wartime duties, the work of the Mines Medical Service consists in the inspection of mines from the medical point of view with particular reference to first-aid and ambulance services; in exercising a general supervision over all matters affecting the health of miners; and in ensuring that they get the best possible value from the hospital services available. The Mines Medical Service maintains a close liaison with the Miners' Welfare Commission and the medical services of other Government departments, and, in matters of research, with the Medical Research Council.

Work on the diagnosis, prevention and treatment of occupational diseases will in time form an increasingly important part of the activities of the Mines Medical Service.

A special sub-Committee of the National Coal Board is deputed to deal with matters concerning the health and welfare of miners and to make recommendations to the Minister. The Ministry of Fuel and Power is represented on committees and panels of other organisations dealing with questions of industrial health, *e.g.*, the Industrial Health Advisory Committee and the Advisory Panel on Dermatitis in Industry, both of which were set up by the Minister of Labour and National Service; the Miners' Rehabilitation Advisory Committee; the Medical Research Council's Committee on Industrial Pulmonary Disease; the standing Inter-departmental Committee on Medical and Nutritional Problems (the Jameson Committee); the Artificial Irradiation Committee of the Industrial Health Research Board; the Industry sub-Committee of the Research Board for the Correlation of Medical Science and Physical Education; and the Inter-departmental Committee on the Educational Needs of Young Persons in the Coal Mining Industry (Ministry of Labour). It also has an observer on the sub-Committee of the Ministry of Health Medical Advisory Committee on Chronic Rheumatism.

# Home Office

*Whitehall, London, S.W.1. Telephone : Whitehall 8100.*

*Secretary of State and Minister of Home Security: The RT. HON.  
HERBERT MORRISON, M.P.*

## **Prisons and Borstal Institutions**

**T**HE Home Office is concerned with the treatment and punishment of offenders from the time of their arrest onwards. The Prison Commissioners advise the Home Secretary on prison administration, including Borstal Institutions, and young persons between the ages of 16 and 23 can be committed to Borstal Institutions by the courts for a period not exceeding three years.

The Home Secretary advises the King on the exercise of the prerogative of mercy ; this includes free pardons, conditional pardons and remissions.

## **Care of Children and Young Persons**

The Home Office is the Government department concerned with the Children and Young Persons Act 1933. This Act applies in England and Wales and covers :

The protection of persons under 17 against cruelty, ill-treatment and neglect ; the provision of Juvenile Courts to deal with boys and girls under the age of 17 who are charged with offences, or brought before the court as beyond control, or in need of care or protection, or—if of school age—for truanting from school ; the various forms of treatment which the Juvenile Court may order, including placing under the supervision of a Probation Officer with or without a condition of residence, committal to the care of the local authority or of some other fit person, and committal to Approved Schools ; the regulation of employment of children, and of street trading by persons under 16.

The Home Office is also the Government department concerned with the Adoption of Children Act 1926, which provides for legal adoption, and the Adoption of Children (Regulation) Act 1939, which regulates arrangements made for adoption by private individuals or adoption societies.

## **Probation**

The probation service in England and Wales is under the central administration of the Home Office, which administers grants and is responsible for inspection of the work of probation officers.

There is a central training scheme which selects and trains suitable candidates for consideration by local justices. The probation officers outside the Metropolitan districts are appointed by the local justices, and their appointments are confirmed within 12 months by the Home Secretary.

In the Metropolitan district they are appointed by the Home Secretary, and their appointments are confirmed in the same way as that of provincial probation officers.

# Ministry of Labour and National Service

*St. James's Square, London, S.W.1. Telephone : Whitehall 2600.*

*Minister: The RT. HON. ERNEST BEVIN, M.P.*

THE Chief Inspector of Factories in his Annual Report for 1943, presented in September 1944, stated that a slight fall in the total number of accidents was encouraging, in view of the increased numbers of young and elderly workers in the factories. The burden of women factory workers with home responsibilities, is being eased by the work of local authorities and voluntary bodies, with the guidance of outside Welfare Officers of the Ministry of Labour and National Service.

Discussions have taken place between the Department and representatives of some of the older industries and of workers, to consider the best means of overcoming the technical difficulties in the way of bringing conditions up to the standard of the Factories Act 1937.

Noteworthy events during the year were the Industrial Health Conference, the appointment of an Industrial Health Advisory Committee (with an Industrial Dust Hazard Panel), decisions to set up a panel on radiological problems and an informal advisory committee on factory seating, and the institution of an information service to provide references on relevant subjects for use in special investigations by the staff of the Factory Department, and to deal with inquiries.

Reference is made to the possibility of the development of communal factory buildings, giving to the occupiers of smaller factories the advantages of modern design, heating, ventilation, lighting, maintenance, communal amenities and labour saving machinery.

Some real advance is reported in accident prevention, which is receiving increasing attention in the factories. The Royal Society for the Prevention of Accidents has collaborated in a special wartime accident prevention campaign, aimed chiefly at ensuring the effectiveness of safety organisations within the factory. Lectures on the Factories Act 1937 and on accident prevention were given to foremen during training courses organised by the Department, to various bodies by inspectors, and training courses for safety officers were held.

There has been a reduction in the hours of work for women and young persons to about a 50- to 52-hour week.

In addition to the normal work of factory inspection, both district and headquarters staff dealt with special tasks, many of which are of a secret character; the medical and technical inspectors are consulted more and more on new processes that involve a safety or health risk, and growing co-operation on the part of other Government departments and the Services is reported. The ground covered includes co-operation with the National Physical Laboratory in planning and carrying out tests on workers dealing with radio-active substances and x-rays; agreement with the supply ministry concerned and the trade, regarding safety arrangements in the grinding and screening of magnesium powder, in the production of aluminium powder by the blowing methods, and in the use of leaded petrol; the legalisation of

special precautions against fire in the testing of aircraft engines ; the issue of an order embodying suggestions for dust control, medical examination etc. in the patent fuel industry ; the consideration of measures to improve methods of dust extraction in the flax industry ; the improvement of ventilation in electrical power stations ; the investigation of methods for prevention of dust in steel foundries, and of the health risks from welding ; the elimination of the employment of young persons and the improvement of conditions for adults in the work of scaling and cleaning ships' boilers and cleaning oil-fuel tanks or bilges in ships ; and progress in implementing the agreement reached in 1941 as to safety and welfare conditions in drop forges. Other matters requiring the attention of the Department are the safety of tackle for the lifting of heavy weights in the fighting services and by civil rescue squads ; dangers of explosion in the manufacture of potato flour, in grain drying and in the manufacture of ferro-manganese ; the manufacture of self-sealing tanks for aircraft ; investigation of conditions during the laying of pitchmastic floors ; and war lighting.

In addition to giving advice on questions of safety and welfare, inspectors are kept in close touch with important industrial developments by service on committees of the Medical Research Council, the Ministry of Health, the Department of Scientific and industrial Research, the British Standards Institution and other Government departments, and similar bodies dealing with medical, chemical, engineering and electrical matters.

The Department is engaged on problems concerning the maintenance of reasonable working temperatures in factories, general ventilation and localised exhaust ventilation, lighting, washing accommodation, and welfare provision in connection with building and constructional works.

Increased demands are made on inspectors for lectures and demonstrations, in connection with health and safety "weeks" in factories and as a basis for discussion with workers.

**Industrial Health :** H.M. Senior Medical Inspector of Factories reports "a year of technical effort paralleling a new high peak of production on the Industrial Front." It is stated that there is an acute shortage of people with professional and technical qualifications, who are also proficient in the scientific and practical aspects of industrial health, and more co-ordination of existing resources and the provision of new facilities for instruction and research, are advocated. There is also need for appreciation of the composite nature of industrial health problems, a progressive outlook towards industrial health on the part of those engaged in industrial research, and co-operation between the medical and non-medical aspects of industrial health. Such co-operation is working effectively in the case of the Industrial Health Advisory Committee and the Advisory Panels, and members are linked also with such bodies as the Ministry of Health and its Medical Advisory Committee, the Medical Research Council and the Industrial Health Research Board.

A remarkable growth in health consciousness among the industrial population is noted, and is largely explained by the expansion of medical supervision and of nursing and welfare services, that resulted from the Factories (Medical and Welfare Services) Order 1940, and also by the educational activities of various ministries and voluntary bodies, and the unions and shop stewards.

In addition to committee work, revision of departmental publications,

publication of articles in the professional press, lecturing, and special investigations, the Medical Branch has been actively concerned in questions relating to the mobilisation of industrial medical officers and industrial nurses, and their substitution; the further training of first aid personnel in industry; the design and lay-out of ambulance rooms; seating of workers; aspects of industrial dermatitis and the constitution of barrier creams; investigation of eye strain in the assembly of radio valves; rehabilitation; nutritional requirements of workers exposed to T.N.T.; aspects of pneumokoniosis and industrial cancer; possible health hazards of projected processes; Vincent's angina; the position of industrial health in the comprehensive health services; investigations into the use of various toxic solvents, and a continuous check of the effects of these and of radio-active substances by means of blood examinations; extension of medical supervision in dock areas; unusual cases of occupational cramps; risks from methyl bromide; occupational risks to the workers in the Land Army; and other special matters in conjunction with the Services and supply ministries.

Medical supervision in factories is stated to be limited by the shortage of doctors and nurses. A chiropodist service has been extended to more Royal Ordnance factories and a dental service started in 15 factories, while care of the working expectant mother has received special consideration.

**Personnel Management :** The Factories (Medical and Welfare Services) Order 1940 enables the Chief Inspector to direct firms to appoint supervisory officers for the welfare of employees. A shortage of trained and experienced personnel managers and welfare supervisors is noted, despite arrangements at the beginning of the war for a three months' course at four universities for selected persons, and part-time courses for others. The Deputy Chief Inspector also notes some lack of organisation in certain personnel departments, lack of immediate access to the directorate in about half the factories, and inadequate assistance for the personnel managers.

Numerous instances are given of improved conditions and happier atmosphere following the introduction of trained personnel, but it is also appreciated that, even without emphasis on welfare, factories where the primary concern of the management is the contentment and well-being of the work-people, present a happy atmosphere.

**Canteens :** Steady progress in the development of canteens, principally in the standard of food and services, is reported. The Factories (Canteens) Order 1943 includes within its scope, factories connected with civilian needs rather than with the manufacture of munitions, and strengthens the legal position in relation to the actual standard of services maintained as distinct from the mere provision of a building and equipment. This has helped the inspectorate to persuade occupiers to raise the standards in their canteens. There was a steady increase in the number of canteens in all types of premises, especially in the smaller factories. The Ministry's Factory Canteen Advisers devoted the major part of their time to catering problems, aiming at better balanced menus with greater variety of choice, and suitable methods of cooking to retain the essential content of food. Attention has also been directed towards the provision of lighter snacks for lunch, snacks for mid-spell breaks, nutritional needs of persons suffering from gastric troubles and of young persons, and meals for night workers. The value of good canteen committees is stressed.

# Ministry of Pensions

*18, Gt. Smith Street, London, S.W.1. Telephone : Abbey 1200.*

*Minister: The RT. HON. SIR WALTER WOMERSLEY, J.P., M.P.*

THE Ministry of Pensions has an important part to play in the various State schemes for maintaining the health and social welfare of the nation. On the proper administration of its beneficent services depend in no small measure, the well-being of many persons disabled as the result of the present war and their ultimate restoration, as far as their disablement will permit, to their proper place in the community.

Among the principal functions of the Ministry of Pensions are the grant and administration of war pensions. Its responsibilities cover not only members of the armed forces—the Royal Navy, the Army, and the Royal Air Force—but extend to members of the Merchant Navy, fishing fleets, pilotage and the light vessel services, salvage service, naval auxiliaries, members of recognised Civil Defence organisations, and also to civilians who are disabled or killed by enemy action.

Entitlement to pension necessarily differs somewhat between the various classes mentioned. The Ministry is responsible, for instance, for compensation in respect of disablement or death arising out of any factor of service in the armed forces during the war, but in the case of members of the Merchant Navy the normal risks of whose calling are still covered by Workmen's Compensation or similar payments, disablement or death is covered by the Ministry's scheme only if it is due to enemy action or circumstances arising out of abnormal conditions imposed by the war. Civil Defence members whose injuries arise out of, and in the course of, the performance of their duties, and civilians who meet with injuries caused by enemy action or by war operations against the enemy, are also covered.

The Minister of Pensions has repeatedly emphasised that the grant of compensation for war disablement is not enough, and that the Ministry must always have in the forefront as its objective the restoration of disabled men and women to physical and mental health, so that they may enjoy the amenities of life and resume their places as useful members of the community. To this end the Ministry of Pensions works in close co-operation with the Ministry of Labour and National Service in the schemes for resettlement and rehabilitation.

Treatment is an important consideration. Where medical, surgical or rehabilitative treatment is found to be required on account of the pensionable disablement, the appropriate treatment is provided by the Ministry if it is not already available from other State sources, such as under the National Health Insurance scheme or the general tuberculosis schemes of the local authorities. Special allowances are payable during any course of approved in-patient treatment, whether in a Ministry hospital or elsewhere. Even in cases where entitlement to pension cannot be admitted, treatment may continue to be provided with a modified rate of allowances up to a period normally not exceeding six months, if at the time of discharge from the forces the member is still in need of in-patient treatment.

The Ministry has an extensive limb-fitting service staffed by highly skilled and experienced surgeons and instructors, and training in the use of



artificial limbs plays a large part in the Ministry's rehabilitative measures for those who require such prostheses.

The Ministry's medical services also include the provision of surgical boots and appliances, artificial eyes, spectacles and dentures which are required as the result of the pensionable condition.

Payment of allowances may be made, where necessary conditions are fulfilled, in addition to disablement pension, in respect of a wife and children, the cost of the children's education, constant attendance on the pensioner, unemployability, etc. Provisions are also made for the payment of pension and allowances to widows and children and also to dependants, where the qualifying conditions are fulfilled.

There are other humane sides to the Ministry's work apart from those already mentioned. The Minister, has, for example, the duty of providing for the care of children who become orphans as a result of enemy action, whether they are children of members of the armed forces, Mercantile Marine, Civil Defence forces, or of civilians. In cases where the children are suffering from neglect or want of proper care, he may in fact become their legal guardian. The Ministry is also responsible for the administration of the War Service Grant scheme under which grants are made to members of the forces who by reason of their service are unable to meet their commitments.

Central control is exercised from the headquarters of the Ministry, but Regional Offices have been set up for the entire purposes of local administration. To assist persons in presenting applications to the Ministry, War Pensions Committees have been established, who avail themselves of the services of voluntary workers.

## Office of the Minister of Reconstruction

*4, Richmond Terrace, London, S.W.1. Telephone : Whitehall 1234.*

*Minister: The RT. HON. LORD WOOLTON, C.H.*

THE post of Minister of Reconstruction was created in November 1943, when Lord Woolton was appointed to it, with a seat in the War Cabinet.

The Minister of Reconstruction's task is : To foresee the main needs of post-war reconstruction and to view them as a whole ; to ensure that adequate plans are made for the transition from a wartime to a peacetime economy ; to ensure in respect of both the transitional period and the post-war period that the plans of departments are properly co-ordinated, that no gaps are left between departmental schemes and that there is no overlapping or conflict between them.

The necessary machinery exists at the ministerial and official levels to enable the Minister and his staff to carry out the Minister's co-ordinating function.

# Ministry of Supply

*Shell Mex House, London, W.C.2. Telephone : Gerrard 6933.*

*Minister: The RT. HON. SIR ANDREW REA DUNCAN, G.B.E., M.P.*

THE Chief Medical Officer of the Ministry of Supply exercises medical supervision in the Royal Ordnance factories, and has in many ways expanded and co-ordinated facilities so as to provide a complete service in essential matters. Health surveys have been carried out and careful attention given to rehabilitation. Special workshops have been set up in six of the larger factories where operatives can work on selected jobs under close medical supervision until they reach full productive capacity.

The care of the working expectant mother receives particular attention. Close supervision of the work is maintained and ante-natal clinics have been established in some factories. These are not intended to take the place of supervision by the woman's own doctor or the local authority's clinic, but rather to supplement those facilities while she remains at work and to provide additional safe-guards in relation to her specific employment.

In every factory there is one (and sometimes two or more) full-time or part-time medical officer and there is a nursing service which consists of: Senior sisters who are State-registered nurses and who are responsible to the officers and in charge of the nursing staff and administrative side of the medical department; group sisters, who are State-registered nurses and who perform normal surgery duties; and nurses, not fully trained, who work under the supervision of the sisters and have no responsibilities and are, therefore, not left in charge. From time to time nurses take refresher courses.

In many Royal Ordnance Factories there are dental and chiropodist services, which have recently been considerably extended.

Regular instruction in first-aid is given by the factory medical department to those interested and a number of qualified first-aiders are working in offices and shops.

In certain cases ultra-violet ray, infra-red ray and radiant heat treatment are given and simple x-ray work is carried out by the nursing service.

# War Office

*Whitehall, London, S.W.1. Telephone : Whitehall 9400.*

*Secretary of State for War: The RT. HON. SIR JAMES GRIGG, K.C.B., K.C.S.I., M.P.*

ARMY welfare work makes provision for the spiritual, mental and physical needs of the men, and provides also a useful informal link between officers and men. It is planned with the object of improving a soldier's fitness both for military and civil life.

**Unit Welfare :** This is the more important section of the work and covers every aspect of the soldier's well-being in the unit. This includes routine matters such as leave, messing, mail, pay and allowances. Saving is encouraged through the Army Savings Association (in 1943 there were over 16,000 organised savings schemes in the Forces). The soldier may consult about his private affairs with an officer, padre or local welfare officer, and can make use of the free legal aid system. Officers give formal and informal talks, and receive complaints, and take part in the army education scheme and current-affairs discussions. Facilities are provided for attending religious services, and contact can be made with the unit or visiting padre. The health of the soldier is cared for by carrying out the rules of sanitation ; pamphlets are issued and talks given by qualified officers on all aspects of health, in addition to medical treatment. Sport and games are shared by officers and men. Entertainment is provided either by visitors (ENSA or voluntary groups) or the unit itself. This includes concert parties, plays and play-readings, dances, B.B.C. features and miscellaneous activities (such as debates), while provision is made for individual pastimes of reading, writing and hobbies. Regimental Welfare Funds (*e.g.*, income derived from NAAFI rebates) are spent on such things as games equipment. Institutes available include NAAFI canteens (for units over 100 strong), reading and writing rooms (including libraries and current publications) and equipped recreation rooms. Good relations with civilians are fostered by mutual hospitality where possible. Attention is also given to relations with Allied and Dominion troops, inter-unit sports, concerts and visits. Finally, a man who is discharged receives advice and information concerning agencies which will help him.

**The Directorate of Army Welfare Services :** The Directorate with headquarters at the War Office, covers the other aspect of army welfare, supplementing the work of the unit. In respect of army welfare, the object is to help regimental officers in providing for the welfare needs of their men in time of war. Welfare officers, who hold voluntary and unpaid appointments, are attached with the rank of colonel to the staff of the G.O.C.-in-C. of each command. Each of these is assisted by county and local officers, and county committees. In overseas commands there is a paid welfare staff in all formation, area, etc. headquarters. These local officers visit units and detachments, advise officers and men about public services in their area and help soldiers with personal problems. They also consult with units over, and assist in, the provision of social facilities such as canteens, and in general act as links between units, the civil population and local authorities. Financial grants are available from public funds for general welfare and entertainment, and from private funds (the Nuffield Fund for the Forces, the Army Council's Central Fund, the Director of Army Welfare Services' Private Fund, local county funds and command and unit private funds). The welfare amenities provided include cinema shows at public cinemas, ENSA performances, assistance to Service concert parties, gramophone concerts, the provision of wireless sets, musical instruments and gramophones ; recreational books and literature, supplied free or at concessional rates ; institutes and canteens to supplement NAAFI, organised by the Council of Voluntary War Work ; hostels and rest-rooms in many towns equipped and staffed by voluntary organisations. There are also

quiet rooms in every command for writing or study, railway station facilities, grants for sports-gear, materials for horticulture and comforts for troops overseas. The Army Welfare Services maintain a very close liaison with the Soldiers', Sailors' and Airmen's Families Association and the Soldiers', Sailors' and Airmen's Help Society, which by means of home and overseas branches, give advice and assistance to the soldier on family and personal problems. Legal advice and assistance is provided through the Army Welfare Services legal aid organisation. Finally, the Army Welfare Services control and operate a world-wide system of army broadcasting, and they also publish army newspapers and periodicals in all overseas commands.

**Army Education:** The Director-General of Army Education at the War Office co-ordinates the work of the Directorate of Army Education and the Army Bureau of Current Affairs (ABCA). In commands at home and abroad, Education and ABCA are organised by the Army Educational Corps.

Every unit has a unit education officer who, in addition to his normal duties, is responsible to his commanding officer for the unit's educational activities. As much use as possible is made of educational resources within the Army. In addition, civilian assistance is supplied by the Central Advisory Council for Adult Education in H.M. Forces, which has 23 regional committees covering Great Britain and Northern Ireland.

The Activities of Army Education include lectures, instruction in citizenship, classes in a wide variety of subjects, handicrafts, correspondence courses organised by the War Office, educational films, discussion groups, informal debates, literary, dramatic and art circles, visits to places of interest, etc. In many stations there are educational centres which cater for the culturally minded soldier. The facilities of Army Education are all available to the A.T.S.

## Department of Scientific and Industrial Research

*24, Rutland Gate, London, S.W.7. Telephone: Kensington 9022.*

*Responsible Minister:* THE LORD PRESIDENT OF THE COUNCIL.

THE Committee of the Privy Council for Scientific and Industrial Research was appointed by Order in Council dated 28th July, 1915 (amended 6th February, 1928) to direct the application of any sum of money provided by Parliament for the organisation and development of scientific and industrial research. The Order also appointed an Advisory Council, to whom all proposals for researches stand referred. On 15th December, 1916 a separate department, having its own Parliamentary vote, was created for the service of the Committee.

# Scottish Office: Department of Health for Scotland

*St. Andrew's House, Edinburgh, 1. Telephone : Edinburgh 33433.*

*Secretary: G. H. HENDERSON, C.B.*

**T**HE Department of Health for Scotland is the department of the Secretary of State for Scotland concerned with housing and town and country planning : with environmental services such as water supply and general sanitation : with public health services such as the supervision of food supplies and the control of infectious disease (including the port sanitary service) : with social welfare services such as national health insurance and contributory pensions, public assistance and welfare of the blind : with personal health services, including the general practitioner service under National Health Insurance ; the local authority treatment services for general sickness, infectious diseases (including tuberculosis and venereal diseases), maternity and child welfare, cancer, and schoolchildren ; and the Highlands and Islands medical service.

**General Medical and Other Services :** The Department is the central authority for the administration of the Public Health Acts in Scotland, and exercises—in relation to the local health authorities—broadly the same functions as the Ministry of Health in England and Wales. The services include the provision of facilities by the local health authorities for the treatment of infectious diseases, including tuberculosis and the venereal diseases ; port sanitation ; supervision of the food supply ; supervision of arrangements for the provision of local authority general hospitals and for cancer treatment. The Department is responsible also for supervision of the arrangements for the provision of medical treatment under the National Health Insurance Act. The Highlands and Islands medical service has been directly administered by the Department since 1913. Under that service special Exchequer grants are given in aid of the hospital, medical, surgical and other specialist services and the district nursing service.

The Department supervises the arrangements made by county councils and town councils of large burghs, for attending to the health of expectant and nursing mothers and of children under five years of age. These arrangements include schemes for providing a doctor/midwife service for women who are to be confined at home, and the provision of maternity hospitals, ante-natal, post-natal and child welfare clinics. The training of midwives and health visitors is also an interest of the Department.

It is for the Department to ensure that the necessary provision is made by education authorities for the medical inspection, supervision and treatment of school children and, in general, for the maintenance of their health and physical well-being.

**Housing :** The Department is the central authority responsible for the administration in Scotland of the Housing (Scotland) Acts and for the distribution of housing grants to local authorities. It approves housing sites selected by local authorities and the plans, and contracts for local authority housing schemes. In addition the Department is charged with the responsibility of supervising the operation of the Rent of Furnished Houses Control (Scotland) Act 1943. —

**Town and Country Planning :** The Secretary of State through the Department exercises all the planning powers and planning functions exercised by the Minister of Town and Country Planning in England and Wales.

**Environmental Services :** Such environmental services as water-supply, drainage, refuse and sewage disposal are the concern of the Department which, for example, prepares general surveys of water supplies to enable decisions to be made on extension of water-works, and, in general, advises local authorities on matters affecting the provision of adequate services.

**National Health Insurance, Contributory Pensions and Old Age Pensions Acts :** The Department continues to administer these Acts in Scotland until that work is taken over by the Ministry of National Insurance.

**Special Wartime Services :** The Department is responsible for the supervision of the emergency hospital service, including the administration of a number of special hospitals set up during the war for dealing with war casualties, and has been responsible for the supervision of evacuation and the emergency relief organisation for the homeless.

The Department's supplementary medical service is an interesting wartime arrangement. This is a scheme initiated to assist general medical practitioners to deal with ill-health in young insured industrial workers. It provides consultant and diagnostic services for actual or probable early cases of organic disease, together with, where necessary, periods of recuperative treatment in convalescent homes to counteract wartime fatigue and to prevent serious breakdown.

## Scottish Office : Scottish Education Department

*St. Andrew's House, Edinburgh, 1. Telephone : Edinburgh 33433.  
Secretary: J. MACKAY THOMSON, C.B.*

THE Scottish Education Department is the department of the Secretary of State for Scotland which is the central authority for education in Scotland. The local responsibility for the provision of education facilities, including those for health and social welfare which are part of the education service, rests mainly with the education authorities. In Scotland these are the county councils and the Councils of the four Cities of Edinburgh, Glasgow, Dundee and Aberdeen. The special functions of the Department and of the education authorities in the sphere of health and social welfare fall into the following main classes.

**Medical Examination and Treatment of School Children :** The central responsibility for this part of the education service comes within the province of the Department of Health for Scotland, *q.v.*

**School Meals and Milk :** Education authorities are empowered by the Education (Scotland) Acts to provide milk and meals for children at school.

Milk at a reduced charge is already available to children at practically all schools in Scotland, and education authorities receive 100 per cent. grants on their net expenditure on this provision. Mid-day dinners are not yet available in all schools, but the Department and the education authorities are pressing ahead with plans to make meals available at all schools within the public education system. A small charge is made to cover the cost of the food provided, though the charge is remitted where it would cause hardship. Grants ranging from 70 per cent. to 95 per cent. of the expenditure on the provision of school meals, excluding the cost of the food for other than necessitous cases, are made to the education authorities by the Department. In addition, arrangements have been made with the Ministry of Works to supply, erect and equip, complete kitchens, sculleries and dining-rooms, without cost to the education authorities. Where the authority undertakes such work at its own hand the cost is reimbursed.

**Youth Service :** This service, which is primarily concerned with the provision of social and recreational training of young people after they have left school, was established immediately after the outbreak of the war as a development of the service which had previously been provided under the Physical Training and Recreation Act 1937. On the recommendation of the Department, education authorities have assumed general responsibility for the Youth Service in their areas. The necessary co-operation with the voluntary youth organisations, which have made, and are making, an important contribution to this service, is maintained through advisory youth councils and local youth panels which have been set up by education authorities.

The education authorities receive from the Department under the Education Authorities (Scotland) Grant Regulations, a grant of 50 per cent. on their approved expenditure on the Youth Service, whether on provision made by themselves, or in respect of assistance given by them to local voluntary organisations. The Department also makes direct grants to the national voluntary organisations towards the cost of their development, and to local voluntary bodies in respect of expenditure which the education authorities are unable, for one reason or another, to aid.

Courses for the training of youth leaders are conducted by the national voluntary organisations, including the Scottish Youth Leadership Training Association, as well as by education authorities, and the expenditure on these courses is aided by direct grants from the Department.

The Department is advised on Youth Service questions by the Scottish Youth Advisory Committee, which has been appointed for this purpose by the Secretary of State. In addition to the Departmental staff engaged on Youth Service work, a Development Officer for Youth Service, an Assistant Development Officer and four Regional Organisers—one man and three women—are employed.

**Other Services :** The Department is also concerned with various other services for promoting social welfare, *i.e.* (a) It is the central department concerned with the regulation of the employment of schoolchildren under the statutory restrictions imposed by section 28 of the Children and Young Persons (Scotland) Act 1937, and under the bye-laws made by education authorities under section 29 of that Act ; (b) It co-operates with the Ministry of Labour and National Service, in the general supervision of the arrange-

ments made locally between the education authorities and the Juvenile Advisory Committees of the Ministry for the vocational guidance of boys and girls entering employment ; (c) it is responsible, as the central authority, for the administration of those provisions of the Children and Young Persons (Scotland) Act 1937, relating to juveniles in need of care or protection, and juvenile offenders who are sent to Approved Schools or committed to the care of education authorities as "fit persons."

## Government of Northern Ireland: Ministry of Health and Local Government

*Stormont, Belfast. Telephone: Belfast 63210.*

*Minister: The RT. HON. W. GRANT, J.P., M.P.*

BY an Order in Council dated 26th July, 1944, the Ministry of Health and Local Government was established as the department for the administration of the public services in connection with public health, housing and local government, and all enactments relating to these functions were transferred from the other Ministries to this department.

The new Ministry has been responsible for opening a campaign against tuberculosis on the lines proposed by the Select Committee, whose findings were promulgated in December 1943.

In November 1944 a Health Advisory Committee was appointed to advise the Ministry of Health and Local Government upon the general administration of health and medical services.

A Housing Bill for the provision of housing accommodation by local authorities and the establishment of a Housing Trust in Northern Ireland has been passed by both Houses of Parliament and has received the Royal Assent.

## Government of Northern Ireland: Ministry of Education

*Stranmillis House, Belfast. Telephone: Belfast 67971.*

*Minister: LIEUT.-COL. THE RT. HON. S. H. HALL-THOMPSON, D.L., M.P.*

IN May 1944, the Minister of Education, presenting the estimates of the Ministry, stated that an increase of £17,000 had been spent in the promotion of youth welfare and that large grants had been made in respect of meals-



milk schemes. Thirty new clubs have been established in a year, and summer schools organised by the Youth Committee have been opened for the training of youth leaders.

The Government's White Paper on Education, December 1944, provides for fostering the development of the Youth Service, and suggests the raising of the grants available to education committees in respect of the provision of facilities for physical training and recreation and youth welfare. It proposes to require education committees to provide free medical and dental inspection, and treatment for all children attending primary and secondary (including junior technical) schools (with possible alternative arrangements for senior secondary schools) and for young people under 18 in attendance at day technical courses and part-time continued education courses, and to require parents to present their children for inspection. Education committees should also be required to provide meals and milk in all primary and junior secondary (including junior technical) schools and in senior secondary schools under their management, and to give further consideration to the provision of meals and milk in voluntary senior secondary schools.

In February 1942, the Minister of Education appointed a committee to consider the problems affecting youth welfare in Northern Ireland, and in January 1944 an Act of Parliament was passed to promote youth welfare and to establish a Youth Committee for the purpose.

## Assistance Board

*Soho Square, London, W.1. Telephone : Gerrard 7878.*

*Chairman: The RT. HON. LORD SOULBURY, O.B.E., M.C.*

THE Unemployment Act of 1934 directed the creation of a Board, to be called the "Unemployment Assistance Board," for the administration of unemployment assistance and other purposes connected with Part II of the Act.

The Board consists of a Chairman, a Deputy-Chairman and not more than four members ; its staff are civil servants.

In 1940 the Board's statutory responsibilities were extended to cover the administration of the new supplementary pensions scheme provided for in Part II of the Old Age and Widows' Pensions Act 1940, and the name of the Board was then changed to the "Assistance Board."

In addition to these continuing statutory duties, the Board has undertaken a number of special wartime duties. One of these is the scheme for the prevention and relief of distress due to the war, which is an extension of the unemployment assistance scheme, authorised by the Unemployment Assistance (Emergency Powers) Act, 1939. The other wartime duties are duties for which the Board has no statutory responsibility, and are carried out by the Board's staff as agents for various Government departments. The most important of these are, the administration on behalf of the Board of Trade of advances of compensation for war damage ; the administration on behalf of the Ministry of Pensions of war injury allowances ; and the investigation,

on behalf of the Service departments and the Ministry of Pensions respectively, of application for Service dependants' allowances and war service grants.

The Board's work is administered from about 350 Area Offices, which are grouped into Districts, each under the control of a District Officer. In general, communications should be sent to the local Area Office. If the address of this office is not known it can be obtained from the Post Office.

### **Permanent Duties**

**Unemployment Assistance :** The principal functions of the Board under the Unemployment Act 1934, are "the assistance of persons to whom Part II of the Act applies who are in need of work, and the promotion of their welfare and . . . the grant and issue to such persons of unemployment allowances."

Subject to a test of need, unemployment allowances are payable to persons between the ages of 16 and 65 who are capable of, and available for, work and who are normally in insurable employment. The allowances ordinarily consist of regular weekly payments to provide for the maintenance of the applicant and his dependants, in accordance with Regulations made under the Act and approved by Parliament. The Board may not make provision for medical needs which are the responsibility of local authorities. Anyone who is dissatisfied with the result of his application to the Board for unemployment assistance, can ask to have the matter brought before the local Appeal Tribunal. The Board's officers may also make lump sum grants where these are necessary to meet any exceptional needs.

Application for unemployment allowances are normally made at the Employment Exchange where the applicant is registered for employment, but in the event of urgency, application may be made directly at the Board's Area Office. The weekly payments of allowances are ordinarily made at the Employment Exchange.

**Supplementary Pensions :** Subject to a test of need, supplementary pensions are payable to persons (other than blind persons) who are in receipt of old age pensions, and to widows in receipt of widows' pensions under the Contributory Pensions Acts who are either 60 or over, or have an allowance for a dependent child included in their pension.

Supplementary pensions are ordinarily regular weekly payments, designed to bring the income of the pensioner and his or her dependants up to the standards laid down in Regulations approved by Parliament. A person who is dissatisfied with the amount of the payment granted can ask to have the matter brought before the local Appeal Tribunal.

Forms of application for supplementary pensions are obtainable at any Post Office.

### **Wartime Duties**

**Prevention and Relief of Distress Due to the War :** The Unemployment Assistance (Prevention and Relief of Distress) Regulations 1939 and 1941, made under the Unemployment Assistance (Emergency Powers) Act 1939, and generally known as the P.R.D. Regulations, enable the Board to grant assistance to certain classes of persons, including refugees from abroad, who are not within the scope of the unemployment assistance scheme

but who are in distress because, as a result of the war, they have entirely or to a substantial extent lost their means of livelihood, or because they have been evacuated under a Government scheme. The assistance given is on the same basis as unemployment assistance.

P.R.D. allowances are not payable to persons in receipt of other wartime payments from the State, such as the family allowance of a soldier's wife, but can be paid to cover any initial period of waiting when payment of other State allowances has been delayed. There is no limitation of nationality, or of age above 16.

**Agency Duties :** As agents for other Government departments the Board carries on the following duties :

(a) **War Injury Allowances :** On behalf of the Ministry of Pensions, temporary injury allowances are paid to civilians incapacitated by enemy action, and to members of Civil Defence organisations injured on duty, pending consideration by the Ministry of Pensions of any claim to a pension. These allowances, which are paid on production of medical certificates, are at fixed rates determined by the Ministry of Pensions and are paid without regard to means. Applications for injury allowances are made to an Area Office of the Board. The allowances are paid weekly by means of postal drafts cashable at a Post Office.

(b) **Compensation for War Damage :** On behalf of the Board of Trade, advances of compensation are made to enable persons who have suffered war damage, to effect urgent replacements of essential clothing, furniture, etc., and for certain other purposes, including replacement of tools, and the stocks of small retailers. Where payments are made to replace clothing the Board also issues any necessary clothing coupons. Application may be made at an Area Office, or at the Board's War Damage Section of any administrative centre established by the local authority.

(c) **Investigation of Applications for Service Dependants' Allowances :** Service dependants' allowances are paid by the Service authorities in certain cases, regard being had to the current household income and to the pre-enlistment contribution by the Service member to the household income. The Paymasters send applications to the Board, whose officers make the requisite inquiries into the household circumstances and furnish reports on which the Service authorities make their award.

(d) **Investigation of Applications for War Service Grants :** Special allowances may be granted by the Ministry of Pensions to relieve, within limits, by a continuing grant, those cases of monetary shortage where either the normal provision of the Service allowances is insufficient, or no Service allowance is payable. Application is usually made by the member of the Forces, but if this is difficult or the serving member is overseas, a dependant may obtain an application form at the Board's Area Office. The Board's officers, after visiting the home where necessary, report on the circumstances to the Ministry, who issue the award.

(e) **Replacement of Lost Clothing Coupons :** On behalf of the Board of Trade applications are considered for the replacement of clothing coupons which have been lost or destroyed. With certain exceptions, such as loss due to enemy action, coupons are only replaced if there is special need of

them. Forms of application can be obtained from the local Food Office and are returnable to the Board's Area Office.

(f) Issue of Buying Permits for Utility Furniture: On behalf of the Board of Trade, permits are issued for the purchase of utility furniture. Forms of application can be obtained at Fuel Offices and are returnable to a specified District Office of the Board.

(g) For the Home Office (Foreign Refugees): On behalf of the Home Office, the Board's officers assess the amount of allowances payable to foreign refugees (not qualified for assistance under the Unemployment Assistance or Prevention and Relief of Distress schemes) by voluntary organisations, subject to reimbursement by the Home Office on an agreed basis, or by the Czech Refugee Trust Fund.

## Board of Control

(Lunacy, Mental Treatment and Mental Deficiency Acts)

*Clifton Hotel, South Promenade, St. Anne's-on-Sea, Lancs.*

*Chairman: PERCY BARTER.*

THE Board of Control was established by the Mental Deficiency Act 1913, and reorganised by the Mental Treatment Act 1930. It consists of a Chairman and not more than four Senior Commissioners.

The Board's functions comprise the powers and duties of the Commissioners in Lunacy under the Lunacy Acts 1890-1922; the general supervision of matters relating to the care and control of mental defectives under the Mental Deficiency Acts 1913-38; and the powers and duties conferred upon them by the Mental Treatment Act 1930. The Minister of Health is responsible to Parliament for the work of the Board of Control.

## Central Midwives' Board

*73, Great Peter Street, London, S.W.1. Telephone: Abbey 2414.*

*Chairman: SIR COMYNS BERKELEY, M.C., M.D., F.R.C.P., F.R.C.S., F.R.C.O.G.*

THE Central Midwives Board is the statutory body constituted under the Midwives Acts 1902-36 for the purpose of carrying out the provisions of the Acts. It is composed of 14 members, appointed as follows: One by the Royal College of Physicians; one by the Royal College of Surgeons; one by the Society of Apothecaries; one by the Society of Medical Officers of Health; four by the Minister of Health; three by the College of Midwives; one by the Queen's Institute of District Nursing; one by the Association of County Councils; and one by the Association of Municipal Corporations.

The Board is charged with the duty of framing rules governing the issue of certificates; the conditions of admission to the Midwives' Roll; the regulating of the course of training and conduct of examinations; the supervising and restricting within due limits of the practice of midwives; and the conditions under which midwives may be suspended from practice.

It is also charged with the duty of publishing a Roll of Midwives who have been duly certified under the Act; of deciding upon the removal from the Roll of the name of any midwife for disobeying the rules and regulations or for other misconduct; of restoring to the Roll the name of any midwife so removed when and if again eligible; and of issuing and cancelling certificates. Rules made by the Board must receive the approval of the Minister of Health before becoming valid.

The latest available figures showed that there were 67,112 names on the Roll, of whom 15,868 were practising midwives. Approximately 55 per cent. of practising midwives are also State-registered nurses.

Arrangements exist for reciprocal registration of midwives registered with other bodies, where the standard of training and examination is equivalent to that adopted by the Board. Concessions are also granted in respect of length of training to holders of midwifery certificates awarded by certain overseas authorities.

The training of pupil-midwives is now divided into two parts: Part I (extending over six months for the State-registered nurse, and over 18 months for the non-State-registered nurse), is entirely institutional, and is designed to give the pupil a sound basic theoretical and practical knowledge of midwifery conducted under the best available conditions. It fits the State-registered nurse, to whom a First Certificate is granted on passing the examination, to fill a responsible post in a women's hospital or women's ward; to undertake maternity nursing; to train as a health visitor; and to become the matron of a general hospital that includes a midwifery department. Part II extends over a period of six months for all candidates and is designed to meet the needs of pupils intending to practise as midwives. It includes a minimum period of three months' domiciliary midwifery. Examinations are held quarterly.

There are at present 101 Part I and 88 Part II training schools approved by the Board. A person seeking approval as a lecturer to pupil-midwives must be of consultant status, and his time must be wholly devoted to obstetric and gynaecological work. Approved teachers in training institutions must have been midwives for at least three years, and produce evidence that they are competent to teach pupils.

The Board grants a Midwife Teachers' Certificate to midwives who complete an approved course of instruction and pass the necessary examination.

Eighty-seven training schools have been approved by the Board for the purpose of giving instruction to midwives in the administration of gas and air analgesia, and a Register of midwives holding a certificate of proficiency therein is maintained by the Board.

The new training rules of the Board provide for the attendance, from time to time, of all practising midwives at approved courses of instruction. This requirement has been suspended since the outbreak of war but will be revised as soon as conditions permit.

# Charity Commission

*The Elms, Morecambe, Lancs. Telephone : Morecambe 1387.*

*Chief Commissioner: J. C. G. POWNALL.*

THE Charity Commission was constituted by Act of Parliament in 1853 "for the better administration of charitable trusts" in England and Wales. The powers of the Commissioners do not extend to endowments held solely for educational purposes. These are subject to the jurisdiction of the Minister of Education. The Commissioners do not themselves administer charities.

# General Board of Control for Scotland

*(Lunacy and Mental Deficiency (Scotland) Acts)*

*York Bldgs., Queen Street, Edinburgh, 2. Telephone : Edinburgh 21104.*

*Chairman: SIR JOHN JEFFREY, K.C.B., C.B.E.*

THE General Board of Control was established by the Mental Deficiency and Lunacy (Scotland) Act 1913, and reorganised under the Reorganisation of Offices (Scotland) Act 1939. It consists of a Chairman and not more than seven other Commissioners of whom at least two must be medical Commissioners and one must be a legal Commissioner.

The Board's functions comprise the powers and duties of the General Board of Commissioners in Lunacy for Scotland under the Lunacy Acts 1857-1919, and the general supervision of matters relating to the care and control of mental defectives under the Mental Deficiency (Scotland) Acts 1913 and 1940. The Secretary of State for Scotland is responsible to Parliament for the work of the General Board of Control for Scotland.

# General Medical Council

*44, Hallam Street, London, W.1. Telephone : Langham 2727.*

*President: SIR HERBERT LIGHTFOOT EASON, C.B., C.M.G., M.S.*

THE General Medical Council was established under the Medical Act in 1858. In 1886 the constitution was modified and legislation conferring on the profession the power to choose representatives, was enacted. The Council is composed of 39 members, of whom there are 18 appointed by the universities in the United Kingdom or in Eire having faculties of medicine (either medical practitioners or laymen); nine appointed by the medical corporations such as the Royal Colleges of Physicians and Surgeons (all registered medical practitioners); five nominated by His Majesty in Council (generally appointed for special reasons relating to departments of the public medical service, and either medical practitioners or laymen); and seven directly elected by the profession (five from England, one from Scotland and one from

Ireland), by postal vote of members having registered addresses in those countries. Under the Dentists Act 1921, three dental members appointed by the Privy Council are added for dental business.

The Council does not formulate professional laws, nor is it a union to protect professional interests. Its function is largely concerned with medical education. The preamble to the Act of 1858 stated: "Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners: Be it therefore enacted . . ." Thus the Act established a procedure whereby qualified practitioners could be recognised, with certain limitations imposed on the unqualified practitioner. Under the same Act qualified practitioners were subjected to a new control, educational and disciplinary.

All qualified practitioners have their names entered on the Medical Register, the keeping of which is entrusted to the General Medical Council, as is the power to remove the name of any practitioner guilty of any crime or professional misconduct. The General Medical Council is, in fact, a Council of Education and of Registration, under the supervision of the Privy Council, who may direct it to amend its errors, if any, or supersede it.

The Council, by virtue of its powers, has become a professional tribunal for deciding whether, in consequence of a conviction or of his own misconduct, a practitioner has become unfit to remain on the Register. The only judgment given when a charge of misconduct is proved is that of "guilty of infamous conduct in a professional respect." The only sentence is the erasure of the guilty person's name from the Register. From this sentence there is no appeal to the High Court, but the Council has power to restore the name of a practitioner to the Register if that can be done with safety to the public.

The Medical Act of 1858 provided that registered persons should be allowed to practise medicine and/or surgery according to their qualifications. In 1886 a qualification in midwifery was added to those in surgery and medicine. The Act also provided for the appointment of inspectors of qualifying examinations. Qualified practitioners who hold a recognised Diploma in Public Health may have that diploma entered in the Register.

With regard to disciplinary procedure, the Council does not initiate proceedings and does not prosecute practitioners. It is a judicial body and takes action only in cases of criminal conviction, or of official censure specifically brought to its notice, or in cases of formal complaint by responsible persons supported by *prima facie* evidence.

## General Nursing Council for England and Wales

23, Portland Place, London, W.1. Telephone: Langham 2819.

Chairman: MISS D. M. SMITH, O.B.E.

THE General Nursing Council for England and Wales is a statutory body appointed to administer the Nurses Registration Act, 1919. It consists of two persons appointed by the Privy Council; two persons appointed by

the Minister of Education ; five persons appointed by the Minister of Health ; and 16 persons elected by Registered Nurses.

The functions of the Council are : To maintain a Register of Nurses for the sick ; and to prescribe the training, and conduct examinations, for admission to the Register.

The Council also maintains the Roll of Assistant Nurses set up under the Nurses Act 1943. Its functions in this respect are similar to those under the Act of 1919.

## General Register Office (England and Wales)

*Somerset House, London, W.C.2. Telephone : Temple Bar 3540.*

*Registrar-General: SIR SYLVANUS P. VIVIAN, C.B.*

THE Registrar-General is responsible for the registration of births, deaths and marriages ; the administration of the Marriage Acts ; the compilation of vital statistics ; the taking of the Census and the preparation of the statistics derived therefrom ; and, since its inception in 1939, for National Registration.

The Minister of Health is responsible to Parliament for the work of the Department.

**Registration of Births, Deaths and Marriages, and the Administration of the Marriage Acts :** The need for a State system of registration of births and deaths with a centralised register of such records, was met by the appointment in 1837 of a Registrar-General with his Office at Somerset House, and the creation of a service of local registrars under his supervision. Concurrently, a revision of the marriage laws provided for the registration of marriages, both religious and civil, and the inclusion of these records in the scheme. Other comparable records have since come into the custody of the Registrar-General, and in the aggregate the entries deposited in the Office had reached a figure of around 160 millions by the end of 1944.

The records are made available to public search by means of indices compiled quarterly, and a certified copy of any entry, receivable as legal evidence, is obtainable upon personal application or by post. Extensive use of the records is also made for the verification of ages and other particulars at the instance of Government departments, *e.g.* in connection with pensions and national insurance.

The local registration service, comprising some 2,100 superintendent registrars and registrars operating in over 500 districts, is administered by the Registrar-General, in association with County, County Borough and Metropolitan Borough Councils, in matters affecting appointments and accommodation.

The local records are preserved in each District Register Office by the Superintendent Registrar, who is responsible for the issue of certificates and licences for marriage after civil preliminaries, and the celebration of



civil marriages in his office. The registrars have the duty of registering births, still-births and deaths upon the information given by qualified informants, and of supplying copies of these entries to the Superintendent Registrars for transmission to the Registrar-General, together with the copies of marriage entries collected by them from the local clergy, etc.

Records are maintained by the Registrar-General of buildings certified for public worship, of buildings registered for the solemnisation of marriage, and of ministers and other persons authorised to register marriages.

Under the Legitimacy Act, the authority of the Registrar-General is required for the re-registration of the births of legitimated children, and it is the duty of the parents of such children to make application to the Registrar-General upon their marriage.

The Register of Adopted Children was commenced in 1927 from the Orders made by the Courts under the Adoption of Children Act. The rate of adoptions has shown a heavy increase in the war years, and the number of entries recorded in the Register reached 100,000 in 1944.

**Statistics :** From the material provided by these records there has been built up a record of the country's vital statistics. A considerable library has thus been formed to which has been added corresponding records for more recent years from all countries which produce and publish similar figures. Since 1921, statistics relating to notifiable infectious diseases have also been collected.

The vital statistics compiled are made available to the public in a series of publications, viz. (a) A Weekly Return of the numbers of births and deaths in London and 126 great towns, including a partial analysis of deaths by cause and age in London, and the numbers of notifications of infectious diseases in every administrative area. It is of historical interest that this is the actual descendant of the weekly "Bill of Mortality" which was awaited and read with such anxiety, particularly during the outbreaks of plague in London; (b) a Quarterly Return of similar character but including also the number of marriages and some analysis for England and Wales of deaths by cause and notifications by sex and age; and (c) Annual Statistical Reviews divided into Parts I (Medical), II (Civil), and Text. Part I contains a full analysis of deaths by sex, age and cause and records of infectious disease; Part II, analyses of births, marriages and fertility; the Text volume includes a critical comment on the salient features of the year's figures, particularly in their relation to past years and in the relation of the various parts of the country to the whole.

In addition, the Registrar-General has been responsible for census undertakings since 1841, and for estimating populations in the whole country and in individual areas for inter-censal years. Census particulars have been published in special volumes, and the inter-censal population estimates are not only included in the publications to which reference has been made, but are supplied to other Government departments and research bodies for their own particular needs. For a number of purposes these estimates have statutory force.

**National Registration :** Upon the outbreak of war the Registrar-General became responsible for the initiation and maintenance of the National Register, which is a record of all civilians in England and Wales at the "appointed time" and of all such persons entering or born in the country

after that time. The census arrangements were used as the basis for the primary enumeration, and the maintenance of the Register involved the establishment of local offices throughout the country. The National Registration Act provided for the issue of Identity Cards to all registered persons.

In addition to its original functions the National Registration records have been made the foundation for the wartime Electoral Registers of the civil population, the Central Office maintaining a register of Armed Forces electors and of British war-workers abroad, who are entitled to vote by proxy.

## King Edward VII Welsh National Memorial Association

*Cathays Park, Cardiff. Telephone : Cardiff 4728.*

*President: MISS G. E. DAVIES, C.H.*

THE Association, established in 1910 as part of a national campaign against tuberculosis in Wales, is incorporated by Royal Charter. In accordance with a scheme made by the Minister of Health under Section 102(3) of the Local Government Act 1929, and other enactments, the Association carries out, on behalf of the 17 county and county borough councils in Wales and Monmouthshire, the statutory duty to make adequate arrangements for the treatment of persons suffering from tuberculosis. It is, in effect, a National Joint Board of Local Authorities for this purpose, the Board of Governors and the Council of the Association consisting predominantly of representatives elected by the said councils.

The Association has provided, or controls, in various parts of Wales and Monmouthshire :

**Institutional Treatment** in five sanatoria and 14 hospitals with a total of 2,000 beds. In addition, the Association rents over 500 beds in outside institutions.

**Modern X-ray Plants** at 16 institutions and completely equipped departments for treatment by ultra-violet rays at five institutions.

**A Mass Radiography Diagnostic Service** by means of a mobile unit, which has been touring Wales since February 1944 and which up to the end of December 1944 had examined some 46,000 persons in industry, ordnance factories, Government offices, etc.

**Out-patient Treatment** at 16 main clinics, all of which are equipped with their own x-ray plants, and at 85 secondary clinics, some of which are also so equipped. Certain of the clinics cater for the continued treatment and supervision of surgical cases under the control of visiting surgeons with special experience in this branch of the work.

**An Educational Staff** consisting of a Director and two whole-time lecturers, through whom the Association is able to bring home to the mass of the people the individual and moral responsibility of every person to assist in the work by taking precautionary measures.

**A Central National Research Laboratory** at Cardiff which works in the closest touch with the treatment centres.

A staff of 50 distinguished specialists in all apposite departments has been appointed, who participate actively in the work and whose services both in diagnosis and treatment are freely called upon.

The Chair of Tuberculosis at the Welsh National School of Medicine was established through the generosity of the first Lord Davies and his sisters. It is held by the Director of Research of the Association, and serves as a link between the School, the Association and its institutions.

The scheme is a comprehensive one and endeavours to stress the preventive, no less than the curative, side of the work. It serves about two and a half million people and concentrates its whole energies upon the problem of tuberculosis. The population is sufficiently large to permit of specialised concentration of effort and to provide adequate material for scientific investigation under controlled condition.

## London County Council (L.C.C.)

*The County Hall, London, S.E.1. Telephone : Waterloo 5000.*

*Chairman: CHARLES ROBERTSON, M.A., J.P.*

THE London County Council is responsible for the administration of the major local government services in the Administrative County of London (117 square miles : population, over four million). Within the Administrative County there are 29 other local authorities—the City of London Corporation and the 28 Metropolitan Borough Councils—who administer other local government services in their own area.

The L.C.C. consists of 124 councillors elected by men and women of London who are over 21 and who are local government electors, or occupy or own land or buildings in the County. These councillors are elected every three years. In addition, there are 20 aldermen, making 144 in all, elected by the councillors and holding office for six years.

Generally speaking, the L.C.C. is concerned with the large-scale services which are best administered over a wide area, and with some exceptions the Council's jurisdiction, as regards such services, extends over the whole of the Administrative County. On the other hand, the City of London Corporation with one or two special exceptions and the Metropolitan Borough Councils are concerned with services of a more local character, and their jurisdiction is confined to their own localities.

The L.C.C. was established by Act of Parliament in 1888 (superseding the Metropolitan Board of Works that had been set up in 1855) and held its first meeting in March, 1889.

As will be seen from the following brief summary of the work and services

of the Council, the activities of the L.C.C. affect, in one way or another, the lives of the people of London every minute of the day and night.

**Education :** The L.C.C. is the authority for all publicly provided education within the County, and maintains over 1,350 schools, providing, in normal times, elementary, technical, secondary and advanced education for 700,000 pupils and students. By the generous provision of scholarships and money grants the Council enables children, however poor, to take advantage of the highest forms of education provided, including that of a university. The Council also has special schools for handicapped children, such as the blind, the deaf, the physically unfit and the mentally afflicted. The Education Act 1944, is likely to bring about extensive changes in London's educational system.

**Hospitals and Medical Services :** See special article by Sir Allen Daley, *page 147*.

**Relief of the Poor and Destitute (Public Assistance) :** The L.C.C. provides help for the poor and destitute of London. This is done in a variety of ways, and it has been the Council's particular concern that those in need shall have the kind of help best suited to their necessities. It has also for many years developed the rehabilitation aspect of this work.

**Welfare of the Blind :** In welfare work for the blind in London the L.C.C. co-operates with various voluntary organisations. Blind children are given special instruction in the Council's schools and are afterwards taught various trades. Blind people are otherwise assisted by wage supplements or money grants. The Council keeps a close watch on their general welfare, and arranges for regular visits to be paid them.

**Housing :** The L.C.C., being the principal housing authority in the County, has carried out extensive slum clearance and rehousing, particularly over the last 20 odd years, and is now one of the biggest municipal landlords in the world. It owns 100,000 dwellings with a population of nearly half a million tenants, who pay over £2½ million a year in rents.

**Main Drainage :** The main drainage of London is the responsibility of the L.C.C., which operates about 420 miles of main sewers. Within recent years the Council has spent over £600,000 on additional sewage purification plant.

**Fire Protection (The London Fire Brigade) :** In peace time the L.C.C. maintained the London Fire Brigade (with a personnel of over 2,000) which was equipped with the most modern appliances and apparatus. This, with the wartime London Auxiliary Fire Service, played a great part in defeating the enemy's "blitz" on London, especially the attempt to destroy London by fire in December 1940. In August 1941, when all fire services were nationalised, the London Fire Brigade and the Auxiliary Fire Service were transferred to Government control.

**Town Planning and Building Regulation—The London Plan :** The L.C.C. is the town planning authority for the whole of London (except the City of London) and is also responsible for certain matters affecting the control of streets and buildings.

**A Plan for the Redevelopment of the County of London** has been prepared for the Council by Mr. J. H. Forshaw, the Council's architect, and Professor (now Sir) Patrick Abercrombie. This Plan, great in its conceptions, proposes a 50-year programme of improvements and redevelopment in the County, and aims primarily at removing the more serious defects of present-day London, while preserving much that is fine and beautiful and enabling more people to enjoy it. The L.C.C. has not yet decided its policy regarding the Plan.

**Highways, Bridges and Tunnels :** The L.C.C. is the central authority for street improvements in London and has carried out various major schemes to improve traffic facilities. It also maintains ten of the Thames bridges in the County and has rebuilt some of them, notably Waterloo Bridge, which was first opened for six lines of traffic in November 1944. The total cost of this great project, including all preliminary works, was £1½ million. Four tunnels under the Thames (two for vehicular and pedestrian use and two restricted to pedestrians) and a ferry across the Thames at Woolwich are also maintained by the Council.

**Parks and Open Spaces—The "Green Belt" :** The L.C.C. maintains 104 parks and open spaces, most of which are inside the County. They vary in size from one to 1,108 acres and their total area is 6,690 acres. In them are provided full facilities for the open-air enjoyment of leisure, with games and athletic sports to suit all tastes and ages. Complementary to them is the "Green Belt" of open land round London, the fundamental idea of which is, that a part of rural England within an average distance of about 15 miles shall be preserved from building. The L.C.C. has undertaken to contribute £2 million towards the cost of land for this purpose.

**Safeguarding the Public :** The Council shares with the Lord Chamberlain the responsibility of the licensing of places of public entertainment in London, such as theatres, music-halls and cinemas, conditioned by rules and regulations framed to protect the public from fire and other dangers. It also tests the London gas and gas-meters and the shop weights and measures, and checks the weight of coal and coke sold in the streets. The Council issues motor-car, driving and employment agency licences.

**Finances :** The L.C.C. spends in peacetime over £40 million a year on the maintenance of the various services for which it is responsible. Its revenue to meet this expenditure comprises Government grants and subsidies, rents, fees and rates. Annual expenditure on major development, which before the war was about £8 million, is financed mainly by the issue of stock.

**The L.C.C. and the War :** During the war all the Council's services vital to the people of London have been kept going.

Half the London air-raid hospital cases received treatment in the Council's hospitals, while facilities for treatment of normal illness have been fully maintained. Throughout the bombing the Council's hospital and health services were never disorganised.

The Council has increased its food production and has more than doubled the land it farms (now over 6,500 acres). It has also provided over 16,000 food-growing allotments in its parks, etc.

The Council is now acquiring most of the London sites needed for temporary houses to relieve the housing shortage.

The Council was responsible for the following civil defence and emergency services in London: The vast evacuation schemes; the recruitment and training of the London Auxiliary Fire Service (now under Government control); the London Auxiliary Ambulance Service; the London Heavy Rescue Service; the War Debris Survey and Disposal Service; the Londoners' Meals Service (British Restaurants); and the air-raid Rest Centres Service.

## Medical Research Council

*c/o London School of Hygiene, Keppel Street, London, W.C.1.*

*Telephone: Museum 3041.*

*Chairman: The RT. HON. LORD BALFOUR OF BURLEIGH.*

THE Medical Research Council was established by Royal Charter in 1920, in succession to the Medical Research Committee (National Health Insurance) established in 1913. It is subject to the general direction of a Committee of Privy Council, consisting of the Lord President as chairman and of the ministerial heads of departments concerned with different aspects of public health, and is financed by a direct Parliamentary grant-in-aid (at present £295,000 per annum), supplemented by payments from other sources for special purposes, and from funds of private origin coming to the Council by gift or bequest. Nine scientific and three other members are appointed by the Committee of Privy Council, and retire in rotation. It is assisted by numerous technical committees in special subjects, including the Industrial Health Research Board.

The constitution gives full liberty to pursue an independent scientific policy for the advancement of knowledge towards the relief of human suffering. In addition, investigations are undertaken into immediate practical problems at the request of administrative departments, and advice is given to the Government on matters involving the latest scientific information. The field covered includes not only problems of disease but also questions of normal health and efficiency.

A research programme is carried out by the Council's scientific staff, either in the Council's own establishments or attached to other institutions, and by recipients of temporary grants for particular investigations in universities, hospitals and elsewhere. The principal establishment is the National Institute for Medical Research (Hampstead and Mill Hill).

The Council's Reports are published by H.M. Stationery Office, and are obtainable through any bookseller; but the results of much of the research work appear in the ordinary scientific periodicals.

Since 1939 the Council's energies and resources have been largely diverted to problems of immediate importance in relation to the war effort, including special work for the fighting services. Direction of certain emergency arrangements of a technical nature is also undertaken on behalf of the Government.

**Industrial Health Research Board:** The Board is appointed by the Medical Research Council and has had the following terms of reference

since July 1942: To advise and assist the Medical Research Council in promoting scientific investigations into problems of health among workers, including occupational and environmental factors in the causation of ill-health and disease, and the relation of methods and conditions of work to the functions and efficiency of body and mind; and in making known such results of these researches as are capable of application to practical needs.

## Miners' Welfare Commission

*Ashley Court, Ashstead, Surrey. Telephone: Ashstead 3262.*

*Chairman: MAJOR-GENERAL THE RT. HON. SIR FREDERICK SYKES, M.P.*

THE Miners' Welfare Commission is a statutory body, appointed by the Minister of Fuel and Power, and consists of three representative colliery owners, three mine-workers and four other members, including an independent chairman. The chief duty of the Commission is to administer the Miners' Welfare Fund in which work it is assisted in each of the 25 coalfield districts by a committee of colliery-owners and mine-workers.

**Miners' Welfare Fund:** The Miners' Welfare Fund is a unique example of health and social welfare provision, organised on a national basis, for a whole industry with monies contributed by every unit of the industry. Workers in coal-mines are peculiarly subject to accidents and occupational diseases, while their social life is often limited to the resources of a mining village or small town. For these reasons, when, following the Report of Lord Sankey's Royal Commission the industry was the subject of legislation in 1920, a levy of 1d. per ton on all coal raised in Great Britain was imposed to provide a fund for "purposes connected with the social well-being, recreation and conditions of living of workers in or about coal-mines, and with mining education and research." The proceeds of this levy, known as the Miners' Welfare Fund, were at first £1,000,000 a year. In 1926 a further levy of 1s. in the £ on mining royalties—producing nearly £200,000 a year—was added. In 1934 owing to difficult times through which the coal industry was passing, the output levy was reduced from 1d. to ½d. per ton, but it was increased to 1d. again in 1939.

The annual revenue of the Fund during the three years 1941–3 averaged £1,042,000. The total receipts during the 23 years to the end of 1943 amounted to £22,104,000 of which all but £812,000 had been allocated in grants to various welfare schemes.

### Recreation

The local choice was first directed to schemes designed to brighten the miner's home life. The Fund was not available for housing, but facilities and accommodation for recreational and other leisure-time pursuits, were early in demand, and grants amounting to £5,922,000, about 27 per cent. of the Fund, have been made for 1,300 schemes, nearly £14,000 per scheme.

The schemes are of all types and sizes, including examples of most forms of social welfare provision, from a park and recreation ground for all sports (with a pavilion), children's playground and perhaps a swimming pool, to a village football field; from a comprehensive community centre in a building of conspicuous architectural merit, comprising rooms for library, reading, billiards, table-games, meetings, a gymnasium, a hall for dances, concerts and drama and even a cinema, to a hut which serves for all social purposes in common. At present the provision for indoor recreation is probably more advanced than any other welfare provision, and it usually takes the shape of a Miners' Welfare Institute with a hall for social functions and rooms for billiards, games, reading and committee meetings.

Measures are being planned for increasing the use of these schemes by developing activities suitable for all age-groups and both sexes, including cultural activities, handicrafts, hobbies, etc., with the ultimate aim of making all the schemes play the part of community centres in the fullest sense.

### **Welfare at the Colliery**

**Pithead Baths :** By 1926 very little locally-initiated progress had been made in meeting the outstanding social need for pithead baths, and it had become evident that other action was necessary. Parliament in that year, therefore, instituted for the purpose the royalties levy, to which the Commission added a small proportion of the output levy and itself assumed responsibility for building baths upon a systematic programme. The annual appropriation averaged about £375,000 at which figure it was stabilised by the Act of 1934. By 1939, however, the accelerating demand had outstripped this provision, and the restored  $\frac{1}{2}d.$  a ton was earmarked entirely for baths. The annual appropriation is now about £800,000 and the total sum expended to 1943 was £6,534,000—30 per cent. of the Welfare Fund.

Before the suspension of building due to the war, baths had been built by the Commission at 343 collieries with accommodation for 426,000 men—about 57 per cent. of the total employed. While its architects department has evolved a new type of installation of high functional efficiency, the Commission has not been content merely to add to the characterless and often ugly buildings so common in industrial districts, but has provided fine, clean-looking buildings, modern in the best sense, which are generally agreed to have reached a high standard of design. The buildings are relieved by the planting of trees, shrubs and grass, in which many colliery companies have collaborated, with a resultant remarkable improvement of the drabness of collieries. This in itself has a definite welfare value.

**Colliery Canteens :** Before the war canteens for light refreshments had been provided by the Fund at 250 collieries, mostly at pithead baths. These have been extended to serve cooked meals, and new canteens have been established to provide miners with opportunities of obtaining extra rations. By 30th September, 1944, wartime canteens had been set up, at a cost of £2,256,948, at 970 out of the 1,028 collieries employing more than 50 men, full hot meals being served at 503 of them.

**Cycle Stores :** These and a variety of other amenities, including clothes-drying rooms, cloakrooms, boot repair shops and houses for baths attendants, have been provided at 252 collieries.



### Health and Safety

**Research :** The work of the Safety in Mines Research Board, which investigates methods of reducing accidents and occupational disease, has been almost wholly supported by grants from the Welfare Fund, totalling £1,233,364, the annual grant before the war having been in the region of £45,000.

**Treatment :** Large grants have been made, chiefly for capital expenditure or endowment, towards institutions and schemes for treating miners suffering injury or sickness. These grants have been directed towards meeting (so far as the money was available) particular needs made known by the district committees and have not been based on any organised plan. Some examples are here given : Miners' convalescent homes (grants for establishing homes, or for purchasing admission tickets)—£2,878,000 ; donations to hospitals—£495,000 ; provision of supplementary ambulance services—£165,000 ; provision of special medical treatment and of surgical appliances (limbs, eyes, spectacles, invalid chairs, etc.)—£130,000 ; district nurses (provision of houses and equipment)—£89,000 ; prizes for competitions for colliery ambulance and rescue teams—£1,500.

**Rehabilitation :** Towards the end of 1942 the Commission undertook, at the request of the Minister of Fuel and Power, to provide centres where injured miners may receive rehabilitation treatment after discharge from hospital, in order the more speedily to regain their full working capacity. The acquisition of suitable premises, their adaptation and equipment, and the engagement of personnel, are surrounded by difficulties at this stage of the war. Nevertheless, six centres provided by the Commission are already in operation under local management committees, and one more will open shortly, while other centres at hospitals have, at the instance of the Commission, been developed or made available to miners. Both capital and maintenance expenditures are met by the Welfare Fund in the case of the centres provided by the Commission.

**Safety Instruction :** The Commission has assisted safety instruction courses, provided by local education authorities and colliery companies, for youths entering the industry, by making grants (of about £7,000) for such purposes as the award of some 33,000 badges for lads who have satisfactorily completed the course.

### Education

Advised by the Ministry of Education and the Scottish Education Department, the Miners' Welfare Commission has devoted considerable sums towards assisting miners and their dependants in higher education : (a) Buildings and equipment for more than 90 institutions of senior, advanced and university courses in mining—£696,000 ; (b) scholarship trust funds (i) restricted to mining instruction—£100,000 ; (ii) for courses of university or equivalent standard in any subject—£185,000 ; (iii) individual grants, bursaries, for students of mining or other subjects—£62,000 ; (iv) lectures, chiefly non-vocational—£73,000 ; (v) miscellaneous education grants—£7,000.

This country has probably the most ample and widespread facilities for mining instruction of any coal-producing country in the world, a position

which would not have been reached but for the generous aid of the Miners' Welfare Fund. While grants were intended to ensure the provision of adequate accommodation and equipment for senior and advanced mining instruction, the senior course is usually preceded by a two years' junior course, for students ranging from 14 to 16 or 17, for which the same premises are commonly used. The senior courses lead up to the examinations for the mine deputy's certificate and certificates of competency for mine managers, under-managers and surveyors, and the degree in mining.

### **Management of Miners' Welfare Scheme**

The schemes are usually established as charitable trusts and the property is vested in local trustees, though membership is not restricted entirely to mine-workers. They are managed by local committees, comprising the trustees and other representatives of the local colliery companies and workers. They are maintained by the subscriptions of the members (usually collected by means of a levy at the collieries) and by charges made for games, entertainments, social functions, etc. Grants from the Welfare Fund are not available for maintenance purposes, but care is taken by the Miners' Welfare Commission not to set up new schemes unless there is good reason to believe that their maintenance is assured.

Generally speaking, miners' welfare schemes have been remarkably successful in dealing with the problems of management and maintenance. The Commission has taken the view that, quite apart from the immensity and intricacy of the financial problems that would have to be faced, if grants were made for the maintenance of the vast edifice of schemes which has been constructed, the success of any welfare work of this sort is directly related to the intensity of the interest of the local people and their readiness to give personal service, as well as subscriptions, for the conduct of the activities centred in the scheme. This is stimulated by giving the beneficiaries the fullest sense of proprietorship in the scheme.

For local committees in need of advice or encouragement, the assistance of experienced welfare officers on the staff of the Commission is available in every coalfield. It is the duty of these officers both to visit the schemes for this purpose, and to investigate applications for grants. They are also able to play an invaluable part in the evolution of schemes, step by step, into comprehensive community centres.

## **Prison Commission**

*Kensington Mansions, Trebovir Road, Earls Court, London, S.W.5.*

*Chairman:* L. W. FOX, M.C.

THE Prison Commissioners are charged with the general superintendence of all local prisons, convict prisons, Borstal Institutions and preventive detention prisons in England and Wales, subject to the control of the Secretary of State.

# International Labour Organisation (I.L.O.)

*Central Office: 3480, University Street, Montreal, Canada.*

*Office in Great Britain: 38, Parliament Street, London, S.W.1.*

*Acting Director (Montreal): E. J. PHELAN.*

THE International Labour Organisation is an official (international) association of states, financed by governments but democratically controlled by representatives of employers' and workers' organisations as well as of governments. Its purpose is to promote social justice in all the countries of the world and thereby to help to secure permanent peace and well-being.

After the last world war, organised workers demanded that they, who had suffered so much from the war, should gain something of permanent value from the Peace Conference. The I.L.O. was, therefore, set up as an organisation which would concern itself specially with conditions of employment and standards of living of working men, women and children throughout the world.

The machinery of the Organisation consists of: The International Labour Office; the Governing Body of the Office; the International Labour Conference.

**The Office:** The International Labour Office acts as the secretariat of the whole Organisation; as a world centre for information, research and advice; and as a publishing house. The government, and the employers' and workers' organisations in any country, can find out from the Office what other countries have done to deal with like problems, and can make use of comparative analyses by experts of the results of various methods adopted in different countries. Governments can obtain the technical assistance of experts in drafting or amending legislation etc. The staff of the Office (from some 40 countries) act as international servants, independent of the government of the country to which they belong.

**The Governing Body:** The Governing Body exercises supervision over the work of the Office; frames its budget; appoints the Director of the Office; and fixes the agenda of the Conference (so far as it is not fixed by the Conference itself). It is composed of 16 government representatives and 16 representatives of employers' and workers' organisations (divided equally between workers and employers), and includes members drawn from every continent.

**The International Labour Conference:** The Conference is a world parliament for the consideration of labour and social questions. Each national delegation to the annual meetings comprises four delegates, two representing the government, one representing organised employers, and one representing organised workers. Each of these three sections speaks and votes independently of the others, so that all points of view find free expression.

The Conference also acts as a kind of advisory parliament, which formulates—after thorough inquiry—international minimum standards to which

national legislation and administration should conform. The decisions of the Conference are formulated in a special kind of international treaty called a Convention or in a less formal Recommendation.

These do not automatically become binding ; the I.L.O. does not dictate to any government or people. But governments are obliged to submit them to their national legislatures.

In the 20 years before the war the Conference held 25 sessions and adopted 67 Conventions and 66 Recommendations. The Conventions have secured nearly 900 formal ratifications by governments. Some of the subjects covered are : Hours of work ; holidays with pay ; regulation of conditions of work of women ; protection of child-workers ; prevention of and compensation for industrial accidents ; insurance against unemployment, sickness, old age and death ; apprenticeship and training for employment ; colonial labour problems ; living and working conditions of seamen at sea and ashore.

The war dealt a severe blow to the I.L.O. but despite difficulties essential staff was by general consent kept together and is now being expanded again. Although the annual sessions had to be suspended, a special Conference—attended by representatives of 34 countries—was held in New York in 1941 and, as if to celebrate its 25th birthday in 1944, the I.L.O. resumed its regular conferences. The New York Conference declared unanimously that the I.L.O. must be represented at the Peace Conference and be associated with the re-planning and reconstruction of the world. The 26th Conference at Philadelphia in 1944, attended by 132 delegates and with 228 advisers from 41 countries, devoted itself to the problems of peace ; the transition from war to peace ; and the laying of the foundations of a prosperous world order.

## United Nations Relief and Rehabilitation Administration (UNRRA)

*Headquarters: Dupont Circle Building, Washington D.C., U.S.A.*

*European Regional Office: 11, Portland Place, London, W.1.*

*Director-General: HERBERT H. LEHMAN, U.S.A.*

UNRRA is a society of governments, which co-operate in order to provide relief and rehabilitation to liberated territories as soon as military conditions permit. Such international co-operation is rendered necessary by the supply situation, and the purpose of UNRRA is to secure an equitable distribution of supplies and to help countries to effect such material repair and restoration as may be necessary to meet immediate basic needs.

The goods and services which UNRRA will endeavour to ensure are as follows : (1) Relief supplies (essential consumer goods to meet immediate needs, such as food, fuel, clothing, shelter, medical supplies) ; (2) relief

services (health and welfare, assistance in securing the repatriation or return of displaced persons, with such technical services as may be necessary for these purposes); (3) rehabilitation supplies and services (materials such as seeds, fertilisers, raw materials, fishing equipment, machinery and spare parts needed to enable a country to produce and transport relief supplies for its own and liberated areas, and such technical services as may be necessary); (4) rehabilitation of public utilities and services so far as they can be repaired or restored to meet immediate needs (as, for example, light, water, sanitation, power, transport, temporary storage, communications, and assistance in procuring material equipment for the rehabilitation of educational institutions).

During the period of military operations in liberated territory, UNRRA can only operate at the request of the military authorities. At the end of the military period UNRRA can operate at the request of, and in agreement with, the national authority concerned, interfering as little as possible with the responsibility and authority of the government. UNRRA's function is "to assess, obtain, transport and distribute supplies and services needed for relief and rehabilitation of areas devastated and disorganised by war."

Various UNRRA Missions are already at work in the field and more are in preparation. Agreements for general relief programmes to take effect at the end of April have been concluded with the Czechoslovak, Greek and Yugoslav Governments. UNRRA personnel are distributing relief supplies in Yugoslavia, in co-operation with the Allied Military Command, as they have been doing in Greece since November last.

The organisation has absorbed, and made use of, preparatory work done by such agencies as the Middle East Refugee and Relief Administration Agency of the British Government, the United States Office for Relief and Rehabilitation Overseas, and the Allied Committee on Post-war Requirements. The policy-making body is the Council comprising representatives of the 44 member-government signatories of the November 1943 agreement. The Central Committee (representing Great Britain, U.S.A., China and U.S.S.R.) acts between meetings of the Council. Executive power is in the hands of the Director-General. Recommendations are made by the Supplies Committee, the Committee on Financial Control, the Technical Standing Committees (Agriculture, Displaced Persons, Health, Industrial Rehabilitation and Welfare) and the Regional Committees (Europe and the Far East).

Funds are provided by contributions from member-governments and may also be received from other sources. While the relief services are available to all countries, UNRRA only provides supplies to countries which have not sufficient foreign currency to pay for their own needs.

The Inter-allied Post-war Requirements Committee estimated that 45,855,000 tons of food, seeds, fuel, clothing, raw materials, machinery and medical supplies would be required by the European countries in the first six months after liberation, and that 23,500,000 tons of shipping would be needed to move the supplies. Negotiations and discussions are being pursued as to the basis of requirements in various aspects of relief. The primary consideration is to be need, irrespective of capacity to pay. The intention is first to stop or avert hunger, and second to ensure a standard of nutrition that will enable the people to make their full contribution to the rebuilding of a prosperous European economy.

Food will take priority over all shipments. Wheat is almost the only staple food of which substantial stocks are available and big shortages are anticipated in milk, meat and fats. It is estimated that imports of 400,000 tons of seeds will be needed to restore Europe to its pre-war state of self-sufficiency. Priority will be given to production of goods for direct human consumption. The aim will be to help liberated territories themselves to produce at the earliest moment as much as possible of urgently-needed goods.

Emergency stocks of medical and health supplies have been prepared to meet conditions of under-nourishment, infant mortality, malaria, typhus, venereal diseases and tuberculosis. Calculations have been made on the basis of population, medical standards, number of hospital beds and other factors. The establishment of international collaboration in public health will be an important task. In this connection, an Epidemiological Centre has been started; minimum requirements have been drawn up for protecting the health of moving populations; and an agreement on quarantine regulations is being prepared. Laboratory units and supplies for completely equipped hospitals are available. A special emergency unit contains all essential supplies for the medical and health needs of 100,000 persons for one month, and units for a population group of a million people for three months are in preparation. Another aspect of this work is the supply of qualified professional services for field work or for assisting the re-establishment of basic health services.

All member-governments, except Russia, have asked for UNRRA's assistance in the repatriation of their nationals from Germany. Arrangements have been made with the Supreme Headquarters for teams of UNRRA workers to help the military authorities in this task. An initial supply of 200 teams has been requested by SHAEF, recruitment for which has been actively in progress since last autumn. The first teams, after a short training, have left for the mobilisation centre in France. Recruitment for further personnel has begun in France, Belgium and Holland, with the co-operation of the respective Governments.

The problems of displaced persons are being examined, and plans made to cope with them, in co-operation with the military authorities and member-governments. The Welfare Division will provide for the thousands of homeless, disabled, aged and other persons unable to provide for themselves. A special agreement having to do with the health and medical measures to be taken in respect of the movements of displaced persons has been prepared and has been submitted to all the European member-governments. In addition, new international sanitary conventions dealing primarily with five diseases (smallpox, plague, cholera, yellow fever and typhus fever) and of world-wide application, have recently been signed in Washington by 19 member governments. These conventions, though having much wider application geographically, will supplement the special Displaced Persons Agreement in respect of the control of epidemics. The convention will facilitate the return of these people by ensuring that the quarantine arrangements are in accordance with modern scientific developments. UNRRA will act as a clearing-house for information on epidemic diseases in co-operation with the Office of International Health in Paris.

Working within the Health Division, the Nursing Section of UNRRA is responsible for advising on all nursing matters and will guide and co-ordinate the nursing programme of UNRRA in Europe. The Royal College

of Nursing maintains a central register of nurses wishing to volunteer for relief work abroad. Originally this was set up in association with the Council of British Societies for Relief Abroad (COBSRA) and used for the guidance of voluntary organisations in appointing nurses for overseas service. UNRRA also calls upon the R.C.N. to send forward details of trained nurses to be considered when appointments are being made.

The above are the latest details at time of going to press.

## Unofficial Statements

### Asthma Research Council

*c/o King's College (University of London), Strand, London, W.C.2.*

*President:* HIS GRACE THE DUKE OF SUTHERLAND.

THE Asthma Research Council was formed in 1927. It is under the patronage of H.R.H. The Duke of Gloucester. Its sole object is research into asthma and its allied disorders. It does not advise on individual cases.

The Council consists of a number of persons particularly interested in the subject of asthma, and its ordinary business is conducted by an Executive Committee. It is advised by an Honorary Medical Advisory Committee.

From time to time the Council has appealed for donations and has also received grants from charitable trusts. From the funds thus available it has made grants towards existing asthma research, and has also appointed its own research workers at hospitals and clinics. Annual reports on the research thus accomplished have been published, and these reports also contain articles of general interest and reviews of current literature on asthma.

Owing to the outbreak of war, the Council's research and the publication of its annual reports have had to be temporarily suspended, but full-scale research will be resumed as soon as possible after the war.

Inquiries (by post only) should be addressed to Miss E. M. Stopford, the Secretary.

### Dr. Barnardo's Homes

*Stepney Causeway, London, E.1. Telephone: Stepney Green 3400.*

*President:* The RT. HON. EARL BALDWIN OF BEWDLEY, K.G.

DR. BARNARDO'S Homes are governed by a Council numbering about 20, elected annually by those who are members of the Association by reason of their interest and help in the aims of the Homes.

The work of Barnardo's, begun by the late Dr. Thomas John Barnardo in 1866, is extensive. Primarily for the rescue and reclamation of destitute waif children, the work of the Homes now extends to lending a helping hand, in almost any case where a child is in need. In spite of the general extension of provisions for dealing with many of the problems affecting children, Barnardo's are always supporting about 8,000. The Homes maintain their strong inter-denominational Christian tradition.



The two outstanding features of the work are : that the Council strictly adheres to Dr. Barnardo's Charter—" No destitute child ever refused admission ;" and that every endeavour is made to give each child a training which will enable it to become a Christian and a self-supporting citizen.

The only two bars to admission are epilepsy or mental deficiency, and as there are no votes or tests other than the need of the child, Barnardo's receive a considerable number of children whose condition calls for medical and surgical attention. Consequently two hospitals, a number of hospital homes and convalescent homes, are provided. After admission, all children likely to obtain the greatest benefit from living in a private household are boarded out, there being usually about 2,800-3,000 such children placed with foster-parents and regularly visited by trained social workers.

In addition to the hospitals, hospital homes and convalescent homes, there are residential homes for "under fives" and for boys and girls aged 5-14. For the older boys, Barnardo's maintain a trade school in which they are taught carpentry, bootmaking, light engineering, printing, tinsmithing, market-gardening, and the Watts Naval Training School and the Russell-Cotes Nautical school for boys intending to enter the Royal Navy or Merchant Navy. For girls there is a Domestic Science School. Many other girls receive training as nursery-nurses and some enter hospital service to become State Registered Nurses. There are hostels for girls training for secretarial work, hairdressing and other careers.

That there are special difficulties to be faced by children during the few years after they first go out to work is recognised. All children leaving Barnardo's are found employment and the Homes try to stand in the place of a thoughtful and helpful parent, giving encouragement, advice and help. This association between Homes and child is a valuable factor in settling the child, and such contacts often continue long after the young man or young woman is firmly established and well on the way to becoming a self-supporting citizen.

Barnardo's have already made provisional plans for the post-war years. Generally these are : An extension of the boarding-out system ; smaller Homes for 30-40 children instead of for larger families, so that the contact between each child and those in charge of the Home may be nearer the ideal of the private family than is possible in a larger Home ; the spreading of Homes throughout the country and the situation of such Homes on the outskirts of towns or large villages, where there are good educational and cultural facilities for children and staff and more opportunity for contacts with their neighbours ; the establishment of one or more reception centres at which the individual difficulties of children may receive expert treatment and advice from medical psychiatrists and educational psychologists.

It is of interest that despite modern legislation and all the help given by the State, local authorities and many other bodies, there is still an overwhelming demand for the services of Barnardo's, as is shewn by the fact that 1,500 children are admitted every year, usually including 200-300 where responsibility for the child is transferred by magistrate's order from the parents to Barnardo's.

Barnardo's maintains over 100 residential homes and "ever-open doors" and has a tradition of prompt help. In the difficult post-war years it should be able to make as great a contribution as at any time during its 80 years of service to children in need.

# Boy Scouts Association

*Imperial Headquarters: 25, Buckingham Palace Road, London, S.W.1.*

*Telephone: Victoria 6005.*

*Founder: The Late LORD BADEN-POWELL OF GILWELL, O.M.,  
G.C.M.G., G.C.V.O., K.C.B., LL.D.*

*Chairman of the Council and Chief Scout: The LORD ROWALLAN,  
M.C., T.D.*

THE Boy Scouts Association, incorporated under Royal Charter, has as its aim, the development of good citizenship among boys by forming their character through training in habits of observation, obedience, and self-reliance, the inculcating of loyalty and thoughtfulness for others, teaching them services useful to the public and handicrafts useful to themselves, and the promoting of their physical, mental and spiritual development.

Scouting is distinguished by its methods. These are based on giving practical and attractive outlets for the normal desires of the boy by turning them to socially valuable purposes. The boy is often unaware of much that lies behind his training. To him it is a great game played with his comrades as campers, pioneers and frontiersmen.

Dean Russell of the Columbia University said: "Scoutcraft is not intended to be a substitute for schooling. It is a device for supplementing the formal instruction of the schools by leading the boy into new fields, and giving him a chance to make practical use of all his powers, intellectual, moral and physical. The best thing about it is its extraordinary diversity, reaching out to boys of all degrees of mental ability in all kinds of social environment and creating for them a real need to do their level best."

A standard of conduct for the guidance of the boy is embodied in the Scout Law. This is as follows: A Scout's honour is to be trusted; a Scout is loyal to the King, his country, his Scouters, his parents, his employers and to those under him; a Scout's duty is to be useful, and to help others; a Scout is a friend to all, a brother to every other Scout, no matter to what country, class or creed the other may belong; a Scout is courteous; a Scout is a friend to animals; a Scout obeys orders of his parents, patrol-leader, or scoutmaster, without question; a Scout smiles and whistles under all difficulties; a Scout is thrifty; a Scout is clean in thought, word and deed.

When a boy becomes a Scout he promises to do his best to live up to this standard. The full Promise is "On my honour I promise that I will do my best: To do my duty to God, and the King; to help other people at all times; to obey the Scout Law."

The order of these is important. "Duty to God" is the basis of religion, and while the scout movement itself is not committed to any one creed, the boys are encouraged to fulfil their obligations if they are already church members, or to accept such obligations by becoming members. "Duty to the King" sums up in a phrase that sense of responsibility to the community which it is the aim of scouting to develop. The "Daily Good Turn" is the first step towards learning how "To help other people at all times." By this simple means it is hoped that a habit of thinking unselfishly may be formed, and the fact that this is perhaps the best known feature of scouting proves its effectiveness. The Law and the Promise are not taught so much by word of mouth as by the whole scheme of practical training. Boys

learn more by doing than by listening but all the activities of scouting are directed by the spirit of the Law and the Promise. Too much emphasis cannot be put on this fundamental basis of scouting. The boy disciplines himself in striving to attain the ideal set before him.

The movement has the following sections: Wolf Cubs (aged 8-11); Scouts, Air Scouts and Sea Scouts (11-18); Rover Scouts (17 and over).

The activities of Wolf Cubs are—in keeping with the psychological needs of their age—set in the imaginative framework of the Mowgli stories from Kipling's *Jungle Books*. Scouts, Air Scouts and Sea Scouts receive the same basic training, but Sea Scouts have additional activities such as boating and sailing, whilst Air Scouts specialise in everything connected with the aeroplane. The Rover branch developed because boys who had been Scouts wanted to remain in the movement when they reached young manhood.

**Organisation:** The organisation of the Boy Scouts is simple. It is based on the principle of decentralisation. The Group is the most important unit. A complete Group consists of a Wolf Cub Pack, a Boy Scout Troop (this may be wholly or partly of Sea Scouts or Air Scouts) and a Rover Scout Crew. A number of Groups form a Local Association (the area covered by this is a question of local convenience). A district under a Commissioner may contain one or more Local Associations. Each district is part of the county organisation under the County Commissioner, who is the personal representative of the Chief Scout and is responsible to him and to Imperial Headquarters. Contact between the Scouters themselves (that is, the adults who are in charge of packs, troops or crews as cubmasters, scoutmasters, or rover-leaders and their assistants) and with the public is maintained by means of committees and meetings of various kinds.

Each unit, from Imperial Headquarters to the Group, is responsible for its own finances; thus Headquarters does not exact a membership fee from Scouts or Scouters. The general principle is that each unit should be self-supporting.

Every Group, many of which are sponsored by churches or schools, has its own headquarters where training is carried out but most of the training is done out-of-doors through hiking, camping, swimming, climbing and many other activities.

The scout movement has spread to almost every country of the world. In 1939 there were 49 countries affiliated to the Boy Scouts International Bureau making a world total of more than three and a half millions. The number of scouts in the British Empire is over one million.

## British Council for Rehabilitation

32, Shaftesbury Avenue, London, W.1. Telephone: Gerrard 4532.

Chairman: The RT. HON. LORD RUSHCLIFFE, P.C., G.B.E.

THE British Council for Rehabilitation, which has recently come into existence, has for its primary aims: To bring together workers in every field of rehabilitation so that all may learn from each, and each from all,

and that the many problems involved may be tackled along co-ordinated lines ; to become a source of information and guidance on matters relating to the rehabilitation services ; to organise short-term courses of study of the various aspects of rehabilitation ; and to promote research into problems as they arise, more particularly those which concern the economic outlook of the permanently disabled.

The Council is in no sense competitive with existing bodies. Indeed leading organisations representative of industry, medicine, education and the social services, and many individuals prominently associated with the various aspects of rehabilitation are already participating in its work. The Ministries of Health, Supply, Labour, Pensions and Fuel and Power have nominated observers.

The Council will serve as a source of information in all matters relating to rehabilitation ; as a forum for discussion ; and as an instrument for constructive and practical achievement. Its programme will be costly and it is appealing for funds.

## British Dental Association

*13, Hill Street, London, W.1. Telephone: Grosvenor 1592.*

*President: J. P. PARFITT, M.R.C.S., L.R.C.P. (Lond.), L.D.S.*

THE British Dental Association, which is under Royal patronage, was established for the promotion of dental and the allied sciences, and the maintenance of the interests of the dental profession by the aid of periodical meetings of members ; the publication of such information as may be desirable through fortnightly journals ; the granting of sums of money for the promotion of the dental and allied sciences ; the encouragement of the Dental Benevolent Fund ; and the maintenance of the separate provisions of the Dentists Acts.

In pursuance of the above objects the Association has over a long period of years interested itself in the dental well-being of the public. Its activities have fallen into three main divisions : Those of its members engaged in private practice ; those engaged in public dental service ; and those engaged in service in H.M. Forces. Standing committees exist for each of these and for many other special aspects of the work of the Association. By means of 16 branches, spread over the whole of the country, its membership of approximately 6,000 is enabled to meet regularly and discuss the problems relating to the profession and to have ready access to the latest developments in the art and science of dental surgery.

In particular the interest of the profession overseas is linked with that of the mother country by a system of affiliation, under which the Dental Associations of all the Dominions and Colonies are affiliated to the British Dental Association.

During its 64 years' history the Association has always pressed for a complete and comprehensive dental service for every man, woman and child in the country. In so far as the public dental services are concerned, there was formed some years ago a Public Dental Officers' Group, which has a membership of over 600.

The Association has prepared a series of reports indicating the means of dealing with the problem of dental treatment in relation to the dental health of the workers, and the dental treatment of the mother, the young child, the schoolchild and the adolescent. Information can be obtained from the Dental Secretary.

## British Legion

*Cardigan House, Richmond, Surrey. Telephone: Richmond 0183.*

*President: MAJOR-GENERAL SIR F. MAURICE, K.C.M.G., C.B.*

THE British Legion, under the patronage of H.M. The King, was formed in 1921 as a result of the amalgamation of four then-existing organisations of ex-Service personnel. Its first Chairman was Earl Haig.

It was started with about 1,200 branches. To-day it has a vast network of 4,600 branches with additional ones being set up continuously. These branches are organised in county groups and a County Committee supervises the general work of all branches. The counties are grouped in regions and presided over by nine area committees who are responsible for dealing with difficult problems of policy, and in most cases, with pension and benevolent cases. The organisation as a whole is controlled by the National Executive Council which is composed of leading figures from areas and counties who are elected by the branches at the Annual Conference.

The branches enjoy considerable autonomy, are vigorous and democratic and exercise a strong influence on the higher committees. To every branch there is now attached a committee consisting not only of British Legion members, both men and women, but of representatives of various other associations and funds.

These committees are in the position to interview ex-Service people, whether members of the British Legion or not, for the purpose of giving advice and assistance on any problem with which they are concerned on their return to civil life. Some of the matters on which advice and, in many instances, financial assistance can be given are mentioned below.

Each of the Legion's branches is in close touch with the local Labour Exchange, and is often able to supplement its work in connection with finding employment. In this connection too the Legion's headquarters and provincial offices are also in close touch with the Special Appointments Branch of the Ministry of Labour, whose function is to find employment of an administrative, managerial, professional or technical character.

Branches are in close touch with the Reinstatement Committee, established under an Act of Parliament to determine disputes between employers and employees in connection with reinstatement in former employment.

The Legion also has the right, on behalf of its members, to appeal to an umpire against a decision of a local Reinstatement Committee.

Servicemen who have lost their small businesses through service, or those who desire to set up in business, can only do so by permission of the Board of Trade who issue a licence for this purpose. The Legion has a representative on every Licensing Committee.

It is also in a position, by reason of arrangements made with a number of trades, to secure expert advice for ex-Servicemen before they venture into a new business.

A member of the Legion will serve on the National and practically all the District Advisory Committees, established by a recent Act of Parliament to advise the Minister of Labour in connection with the training and subsequent employment of disabled men.

The Legion has a number of institutions for the employment of severely disabled men, and is in fact the largest employer of disabled persons in the country.

At its Poppy Factory it employs nearly 400 men, each of whom has lost one or more limbs.

The Legion has the largest centre in the world for the treatment, training and employment of ex-Service men suffering from tuberculosis. This is at Preston Hall in Kent, with an annexe at Bournemouth, Hampshire.

A sister institution for ex-Service women has been established and recently been opened at Nayland Hall in Essex.

The Legion has 156 houses or flats in various parts of the country, that are let at rents which disabled men can afford to pay.

It has representation on all national and local committees dealing with war pensions, and a specially trained staff at headquarters to assist disabled men who are having difficulty with their pension claims.

Skilled advocates are also available at the highest court of appeal in pension matters, namely, the Pensions Appeal Tribunals, and the services of these advocates are at the disposal of claimants, free of charge, whether they are members of the Legion or not. Twenty thousand difficult pension claims were dealt with by headquarters during the past year, over one-quarter of which were successful.

The Benevolent Department of the Legion gives financial assistance to ex-Service men and women who are in need, whether or not they are members of the Legion.

The purposes for which grants are made include: Tools, clothing, cost of travel, cost of removal of home when taking up employment; surgical appliances, special medical and convalescent treatment for claimants or their dependants; dentures when a man is handicapped at work or prevented from obtaining employment by defective teeth; aid on a continuous basis when permanently incapacitated; special training and assistance for claimants' children unable through physical disability, to enter a trade or profession in the ordinary course; advice and assistance towards licences and permits for commodities under control; and aid in many other directions where there is a definite object in view.

Apart from these activities, which are mainly concerned with individual case-work, the Legion as a non-party political organisation continually presses the Government for improvements in provisions for ex-Service personnel, and the Legion's point of view is expressed in every parliamentary debate on ex-Service matters.

Many of the concessions granted since the beginning of the war are the result, directly or indirectly, of the Legion's work, and a campaign is now afoot for preference for ex-Service men in all fields.

# British Medical Association

*British Medical Association House, Tavistock Square, London, W.C.1.  
Telephone: Euston 2111.*

*President: H. S. SOUTTAR, C.B.E., F.R.C.S., F.R.A.C.S., M.Ch.*

*Secretary: CHARLES HILL, M.A., M.D., D.P.H.*

THE British Medical Association is a voluntary association of medical practitioners, formed for the purpose of promoting the medical and allied sciences and of maintaining the honour and interests of the medical profession. Its present membership is over 48,000. It is recognised by the Government departments and by many public bodies as the largest and most representative organised body of medical practitioners. Its activities cover a wide field of medico-political and medico-social work, and it has issued many publications of interest not only to the medical profession but also to the general public.

In the matter of the provision and organisation of medical services the Association's present official policy may be summed up in the following principles: (a) That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness; (b) that there should be made available for every individual the services of a general practitioner or a family doctor of his own choice; (c) that consultants and specialists, laboratory services, and all necessary auxiliary services, together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor; (d) that the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy. The Representative Body in December, 1944 expressed the opinion that "pending further information (i) the Government's intentions on the professional and administrative arrangements both central and local; and (ii) the machinery whereby private practice is to be continued, including safeguards to secure its preservation for those members of the community who are able and willing to provide the medical service for themselves, a comprehensive medical service should be available to all who need it, but that it is unnecessary for the State to provide it for those who are willing and able to provide it for themselves."

The Association has taken the lead in the medical profession's work in connection with the post-war reconstruction of the country's medical services. It initiated in 1940 the formation of the Medical Planning Commission which issued a Draft Interim Report in June, 1942, that is, several months before the publication of the Beveridge Report. Discussions have taken place between representatives of the profession and the Ministry of Health, both before and since the issue of the Government's White Paper on a National Health Service, and a Negotiating Committee has now been formed by the profession to carry the discussions a stage further.

The Council of the Association prepared a Report on the White Paper and when this was submitted to the Annual Representative Meeting of December, 1944, a number of resolutions were passed as instructions to the Negotiating Committee. A summary of the main decisions of the Meeting is appended.

The Association is also at present engaged in the consideration of a number of other topics closely connected with the future of medical services. For example, it is preparing in the form of a Charter for Health, a statement of the profession's views on the basic factors of health such as nutrition, housing, health education, occupation and recreation. Another special committee is occupied with the subject of rehabilitation of injured persons, a large and important problem the discussion of which was initiated by the Association's Report on Fractures in 1935.

#### APPENDIX :

### NATIONAL HEALTH SERVICE PROPOSALS

#### **Main Decisions of the Representative Body**

The more important decisions taken by the Representative Body at its meeting in December, 1944, referred to above, in addition to those approving particular paragraphs of the Council's Report on a National Health Service, are set out below.

**General Attitude :** That this Representative Body warmly welcomes the Government's declared intention "to ensure that in future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health."

That in the opinion of the Representative Body it is essential that the proposed National Health Service should be the best that can be established.

That the Association is prepared to co-operate with the Government to improve the medical service of the country.

That the proposals contained in the White Paper can only form a satisfactory basis for negotiations if altered in essential particulars.

That this meeting considers that the general principles enunciated by the Minister on page 47 of the White Paper are incapable of being realised within the scope of the White Paper proposals.

That while the Annual Representative Meeting is prepared to continue a panel service and would welcome its extension to dependants, which for a quarter of a century it has advocated, and while it desires that cottage hospital facilities, including x-ray and other diagnostic facilities, should be available to every practitioner, together with access for their patients to consultants, it is wholly opposed : (a) to a whole-time State salaried service for general practitioners ; (b) to civil direction of practitioners, to government of the profession by local health authorities—in short, to most of the machinery of the White Paper ; and (c) to any and every measure which tends in any respect to limit the freedom of judgment and of action of the practitioner or to weaken his full responsibility for his patient.

That an extended medical service can only become fully effective when sufficient doctors are available to operate it.

That this meeting generally approves of the constructive criticisms submitted in the Council's report and emphasises its disagreement with the proposals contained in the White Paper for achieving a comprehensive medical service.



**Administration :** That the Association considers that the administrative proposals and the form of control they involve, as envisaged in the White Paper, are inimical to efficiency and progress. In the interests both of the public and the profession the Association is, therefore, not prepared to co-operate in a service so designed.

That the Representative Body wishes to put on record that this Body would resist to the utmost any Government control of doctors in clinical matters, or any interference in the present doctor-patient relationship, and that no doctor be compelled to undertake medical practices which are contrary to his conscience freely exercised.

That the Representative Body, being gravely disquieted by the proposals of the White Paper to place the administration of the service under the Ministry of Health and the local authorities, calls for a thorough and impartial inquiry into the proposed central and local administrative structure of the service.

That the profession should not be controlled by the local authorities as at present constituted.

That in the event of the establishment of advisory councils, this meeting is in favour in each administrative area of a single local health services council representing all branches of medical practice and ancillary services.

That any national medical service must be inclusive of all existing and future civilian medical services.

That no scheme of national health service shall be accepted which does not allow to the individual medical practitioner full rights of scientific and political publication, freedom of speech, including the right to criticise the service, and full political rights.

**Improvement of Social Conditions :** That it is the opinion of this meeting that as an essential corollary to any national health service, it is imperative that the social conditions of the people be improved in the matter of housing, employment, food, and recreational facilities.

**The 100 per cent Issue :** That pending further information on (1) the general professional and administrative arrangements, both central and local, (2) the machinery whereby private practice is to be continued, including safeguards to secure its preservation for those members of the community who are able and willing to provide the medical services for themselves, there be affirmed the view of the A.R.M., 1943, "that a comprehensive medical service should be available to all who need it, but it is unnecessary for the State to provide it for those who are willing and able to provide it for themselves."

**Extension of National Health Insurance :** That health legislation should proceed by evolution, and the Representative Body is of the opinion that the objects aimed at will be achieved by completion of the N.H.I. service to embrace institutional, specialist, and all auxiliary services, and, when this is accomplished, the expansion and extension of N.H.I. to dependants of those insured and to others of similar economic status.

**The Central Medical Board :** That the Central Medical Board, if formed, should not have any powers of direction ; that the Central Medical Board should be composed entirely of medical practitioners.

**General Practice :** That midwifery, as it is the very foundation of family practice, should be left in the hands of the general practitioner, with the provision of special lying-in hospitals where necessary.

That it is in the national interest and essential to the independence of the profession, that doctors should continue to own the goodwill of their practices.

**Voluntary Hospitals :** That the Association feels very dissatisfied with the proposed provisions for the retention and maintenance of the voluntary hospitals, especially in respect to their subservience to local authorities, whether as at present constituted or in the form of joint authorities, and desires a more general representative administration of hospitals and medical services throughout the country.

**General Instructions to Negotiating Body :** That it be an instruction to the Association's representatives on the Negotiating Committee that, without prejudice to other issues, including the 100 per cent. question, remuneration and compensation, consideration of administrative structure, central and local, should precede consideration of all other questions, and that agreement on this subject is an essential prerequisite to discussion of other subjects.

That the Representative Body is of opinion that concession by the Government should be obtained of the following fundamental principles as a preliminary to any negotiations : (a) Freedom of choice by patient and doctor ; (b) non-intervention in professional matters of any third party in the doctor-patient relationship ; (c) medical representation at all levels of administration by election of the profession ; (d) that the evolution of a national health service must be by stages and governed by the availability of medical personnel.

**Legislation :** That in the implementing by legislation of any health service proposals the necessary legislation should be presented in a separate Bill, and the health service proposals should not be incorporated in, nor be dependent on, the financial provisions of the social security measure.

## British Red Cross Society

*14, Grosvenor Crescent, London, S.W.1. Telephone: Sloane 5191.*

*President:* HER MAJESTY THE QUEEN.

THE Society, which is under the patronage of H.M. The King, had its beginnings in 1870, when the National Society for Aid to the Sick and Wounded in War was founded upon the rules laid down at a Conference held in Geneva in 1863, and after some changes, assumed in 1905 the title of the British Red Cross Society. In 1908 it was granted a Royal Charter with the primary object of furnishing aid to the sick and wounded in time of war, and in 1919 received a supplemental Charter authorising the extension of its activities to include the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world.

The Society, through its branches in Great Britain and the Colonies, raises and trains detachments of men and women to serve as auxiliaries to the medical services of the armed Forces, and to other medical and nursing services, and organises courses of instruction in first-aid, nursing and a number of health subjects based on its text books.

In the 1914-18 war an enormous expansion took place and the Red Cross performed outstanding service in effective co-operation with the medical services of the Crown, through a Joint Committee of the British Red Cross Society and the Order of St. John.

In 1923 the Society appealed for funds to establish the British Empire Cancer Campaign, and raised £80,000 in 18 months, thus enabling the Campaign to set up its own organisation.

The outbreak of the present war found the Society's Detachments prepared and mobilisation was effected in 48 hours, members taking their places with the medical services of the armed forces of the Crown, in the Civil Defence casualty services and in the Emergency Medical Service hospitals. Valuable work was done in connection with the evacuation of children and old people, and sick-bays were set up. Assistance was also given in transferring patients from hospitals in vulnerable areas.

A joint War Organisation of the B.R.C.S. and the O. of St. J. (officially recognised and similar to that of the last war) was formed. H.R.H. The Duke of Gloucester's Red Cross and St. John Fund was established and contributions poured in from British people at home and abroad.

Members of men's Detachments answered the Government's appeal for stretcher-bearers for hospitals; commissions comprising personnel, vehicles and stores, were appointed to serve with the B.E.F. in France and the Middle East; women drivers were attached to the Army at home; librarians and diversional therapists were provided for duty in service and emergency hospitals; and members assisted the Wounded and Missing Department of the War Organisation by serving as liaison officers and searchers in hospitals.

The Detachments cared for refugees from abroad, including Gibraltar, and from the Channel Islands; staffed medical posts; and opened rest stations for the troops during the evacuation of Dunkirk. Others helped local authorities to educate the public in elementary first-aid and air-raid precautions. The War Organisation opened many convalescent homes in which the Society's officers and members served as commandants, matrons, sisters, quartermasters, secretaries, masseuses, nursing members, orderlies, drivers and general service members.

Owing to the capture of numbers of British troops and the breakdown of direct communications with Geneva resulting from the fall of France, a heavy strain was thrown on the Prisoners-of-War Department. Communications were gradually established through Lisbon and Marseilles and the supply and despatch of parcels became one of the primary tasks of the War Organisation.

During the Battle of Britain members from London and all parts of the country staffed the first-aid posts in the tubes and other shelters. In bombed cities, towns and villages, Detachments shared in the work of the casualty services. Rest centres for people who had lost their homes were staffed and temporary homes established for old people who had been bombed out.

The Society is governed by a Council which elects a Chairman subject to the approval of the President. The Council appoints annually an Executive Committee and a Chairman. The latter organises the Society, and manages its general business subject to any directions given from time to time by the Council.

The Executive Committee, of which Lord Woolton, Minister of Reconstruction, is the Chairman, has the following sub-committees: Finance sub-Committee; General Committee of the Clinic for Rheumatic Diseases, which administers the B.R.C.S.'s Clinic at Peto Place, London, N.W.1; Detachment sub-Committee, which administers all matters concerning the personnel of the Society and its Detachments; Education sub-Committee, dealing with matters of instruction and training courses, including the preparation and revision of text books and the conduct of lectures and examinations; Nursing Advisory sub-Committee, of which the Matron-in-Chief is Chairman; and the Planning sub-Committee, which investigates all possible avenues of future work.

The Secretariat deals with routine work of the Society and communicates to the Central Council and local branches all decisions of the Council and Executive Committee affecting their work.

The work of the B.R.C.S. throughout the country is carried out by county branches, whose constitution is, to a large extent, autonomous, each county having a president (appointed by the Council) and a county director (appointed by the Executive Committee) who is responsible for the administration of the branch. Each county branch has its own branch committee.

The Society has drawn up a future programme in co-operation with the Ministry of Health, to ensure that the supplementary services suggested shall fit in as required with the new national health service proposals. Contact is maintained with the Ministry of Labour, the Ministry of Education, the Assistance Board and other Government departments as the need arises, also with the headquarters of voluntary organisations with similar interests, so as to avoid overlapping.

While the care of the sick and wounded Service men and women, prisoners-of-war, and civilian victims of air-raids continues to be the primary work of the Red Cross, working through the War Organisation, the Society has not hesitated to accept new responsibilities and to develop experimental work, within the scope of its Charters, in connection with reconstruction, youth and social services.

## Caldecott Community

*Hyde Heath, Wareham, Dorset. Telephone: Bere Regis 90.*

*Chairman: The RT. HON. THE EARL OF LYTTON, K.G., K.C.I.E., K.C.S.I.*

THE Caldecott Community exists for the benefit of normal children (girls and boys) from abnormal homes. In order that such children should not be permanently affected by the unhappy or unstable conditions of their home life, and should have a chance to grow up into good citizens, it is essential that

they should be removed from their homes into an environment of understanding, affection and security.

Under the term "broken home" can be included any home where severe friction exists between the parents; where the parents are separated or divorced; where one parent is dead and the other incapable of looking after the child; where there is chronic illness, or drink, or crime; where the child is illegitimate, and therefore "de-valued"; or where there is an unkind step-parent.

The life at the Community is very simple. There is no ordinary domestic staff; the domestic work is pooled between the general staff and the children; and members of the house staff take a share in teaching and supervising the children. The children under 11 are educated at the Community. Senior children attend the local secondary and senior schools.

There are 100 children at the Caldecott (an almost equal number of boys and girls) ranging from one to 16 years of age, and drawn from every social class.

The average cost of a child at the Community is 45s. weekly. This is paid either by the parents or by the local education authorities, or in a few cases by an individual interested in the welfare of a particular child. In choosing the children due consideration is given to: (a) The comparative urgency and necessity (necessity is not always measured in terms of the greatest material poverty, although this is often a determining factor in making the selection); (b) types of child (other things being equal, preference is given to the sensitive, intelligent child, who in the opinion of the Committee is best able to benefit by the kind of education offered at the Community, and who is also more likely to be seriously handicapped by abnormal unhappy home conditions).

Inquiries should be sent to the School Secretary, Miss Lovegrove.

## Central Council for Health Education

*Tavistock House, Tavistock Square, London, W.C.1. Telephone: Euston 3341.*

*Chairman:* ARTHUR MASSEY, M.D., C.B.E., D.P.H.

THE Central Council for Health Education was initiated in 1927 and is now recognised by the Government as "the one agency for general health education in England and Wales." Its general object is to assist local authorities by educating the public in the use of health services. The following principles were expressed by the Council: "Health of mind and body is the basis of happiness and good citizenship. A community which has the right conception of health will be able to grow harmoniously and face danger. The individual possessing it can enjoy a happy and useful existence."

The present activities of the Council have resulted in a great saving of money over the old, less efficient and economic scheme, whereby each Medical

Officer of Health or Director of Education assembled his own health education material. Now the Council is able to provide a central administrative body which carries out the health education policy agreed by its governing body. On this body are representatives of the Ministries of Health and Education and the local government organisations, and members elected by the Society of Medical Officers of Health, the Association of Secretaries and Directors of Education, the British Medical Association, the National Union of Teachers and by a large body of approved organisations dealing in a voluntary capacity or otherwise, with all aspects of health education. These organisations are affiliated to the Council as the co-ordinating agency.

The subscriptions of local authorities, payable on a quota basis, together with a grant-in-aid from the Ministry of Health, provide for the central organisation which, in addition to the mass production of literature and posters which are available to local authorities at production cost only, makes available the free organising services of area representatives throughout England and Wales and a team of expert lecturers who will undertake at agreed charges, courses of lectures to teachers, youth leaders, nurses and others who may wish to fit themselves for active co-operation in the widest fields of health education.

To facilitate the organising services and to provide opportunity for the study of local conditions, the Council has opened 12 area offices in England and Wales.

It is also enlarging its local panels of approved lecturers in order to undertake work on the spot at the minimum of expense. Local authorities are entitled to a return of one-sixth of their quota payments in the form of free lectures or literature.

The Council has in the past produced a number of films on a wide range of health education subjects, and is now engaged jointly with the Ministries of Health and Information in arranging for the production of further films. These films, together with many others produced from other sources, are available without charge for the use of subscribing local authorities.

As the central co-ordinating body in all aspects of health education, the Central Council has, since 1942, assumed responsibility for education on the prevention of venereal disease and this service is rapidly being integrated in the wider field of general health.

In collaboration with the Ministries of Health and Information, special attention is given to the "diphtheria immunisation" and "coughs and sneezes" campaigns which are carried out with the aid of posters, broadcasts, published articles, leaflets and films. The Council also prepares material for press advertisements which are issued jointly with the Ministry of Health.

Two periodicals are published: one, a popular monthly journal, *Better Health*, with a circulation of from 50,000 to 60,000; the other, a quarterly, *Health Education*, containing specialist articles for doctors and educationalists.

The use of the radio in health education has been rapidly developed and talks have been given by "the Radio Doctor" (who is a Vice-President of the Council), by the Council's Medical Adviser and Secretary and by its Education Officer.

Health education in Scotland is undertaken on behalf of local authorities by the Scottish Council for Health Education.

# Central Council of Physical Recreation

58, Victoria Street, London, S.W.1. Telephone: Victoria 3563.

President: The RT. HON. THE VISCOUNT ASTOR.

**T**HE Council, which is under the patronage of H.M. The King and of H.M. Queen Mary, was initiated in 1935 by the Ling Physical Education Association and the National Association of Organisers of Physical Education. Briefly, the Council's aim is to improve the physical and mental health of the community through the development of physical recreation. The Council is made up of some 133 national organisations concerned wholly or in part with physical recreation and health education, together with a number of interested individual members.

**Policy:** Active co-operation is offered by the Council to all statutory and voluntary bodies working in the sphere of physical recreation. The Council considers that co-ordinated action—without loss of individuality—and the pooling of knowledge, can only strengthen the efforts of those engaged in the promotion of physical fitness throughout the country.

**Sphere of Work:** The Council works on behalf of:

(a) The Ministry of Education, in respect of young people between the ages of 14 and 20 years who have left school. The Ministry has increased its grant to the Council, to enable the latter to extend the facilities it can offer for the development of the Youth Service, and has expressed the hope that local authorities and voluntary organisations will make the fullest use of these facilities for securing trained leaders and help in the organisation of activities such as youth rallies, games schemes, lecture-demonstrations and village "keep-fit" meetings.

(b) The Ministry of Labour and National Service, which has grant-aided the Council to enable it to assist in the provision of physical recreation for adults engaged in work of national importance. In 1942, at the request of this Ministry, the Council gave special help with the "Holidays at Home" campaign, and in 1943 and 1944 it established camps for industrial workers.

(c) The Home Office and Ministry of Home Security, on whose behalf the Council has arranged training courses for selected Civil Defence workers, and generally assisted the development of physical recreation among the Civil Defence and National Fire Services. The Civil Defence Sports Committee, formed in 1941, was administered through the Central Council. At the request of the Home Office in 1943 the Council undertook the organisation of fitness training for firewomen.

(d) The three Service departments, which, together with the Ministries already mentioned, co-operated actively in the "Fitness for Service" scheme which the Council launched in conjunction with the Football Association.

(e) The Ministry of Supply, in respect of workers resident in Royal Ordnance Factories' hostels; the Council gives assistance to organisations responsible for their welfare.

(f) The British Broadcasting Corporation, which has received advice in respect of its programme of early morning exercises.

**Organisation :** On the outbreak of war the Council was employing 12 men and women technical representatives. This number has increased to 67, and in addition three part-time industrial physical recreation leaders have been engaged. The representatives work in co-operation with local education authorities and voluntary bodies, and offered both practical and advisory services. Names and addresses of representatives can be obtained from the Council's headquarters.

**Practical Work :** The Council interprets physical recreation in its widest sense, embracing outdoor and indoor games and sports, "keep fit" exercises, recreative gymnastics and dancing, swimming, outdoor activities such as camping, cycling, walking, and the youth-hostel movement, and practical health education. The Council considers that physical recreation is only one factor contributory to positive health, and that it should become more and more closely associated with all health and social factors and with all factors which affect health such as nutrition, housing, working hours and conditions. The most important aspects of the Council's programme are the training of leaders of both outdoor and indoor physical recreation (in 1942 approximately 600 courses of varying lengths were arranged throughout the country and were attended by some 16,000 trainees) and the rousing of public interest in physical recreation and health education. In this connection lecture-demonstrations, rallies, games schemes and open classes have proved excellent means of propaganda.

A National Test for Leaders of Physical Recreation has been instituted by the Council. The scheme has the approval of the Ministry of Education and is likely to be far-reaching, both during and after the war. Since its inauguration in 1940, the national standard of leadership of physical recreation throughout the country has been favourably influenced, and approximately 700 men and women have become National Leaders. Details of this scheme can be obtained from the Council's headquarters.

## Charity Organisation Society

*Denison House, 296, Vauxhall Bridge Road, London, S.W.1.  
Telephone: Victoria 7334.*

*Chairman of Council: Wing-Commander LORD MALCOLM DOUGLAS-HAMILTON, O.B.E., D.F.C.*

THE Charity Organisation Society, which is under the patronage of H.M. Queen Mary, was founded in 1869 in an attempt to reduce the beggary and pauperism then so rife in London, and consists to-day of a federation of District Committees within the London area, formed from among persons interested or taking part in social work in a particular district. Their general policy and principles of action are determined by a Central Council formed by representatives of District Committees and certain additional members including members of affiliated societies outside London.



The work of the Society is based on the belief that the welfare of the community depends mainly on two things : firstly, a high conception of the dignity of the individual man, and secondly, a recognition of the fundamental importance of family life.

The chief activity of the Society is the promotion of " family case work," which may be described as the art of helping people in trouble so that they may make the best use of their own capacities, with the co-operation of their family and the community, to overcome their difficulties. It also seeks to unite in common action all persons and agencies engaged in family case work and to encourage any new developments to meet new social needs.

The Society takes an active part both in social research and in practical schemes for raising the standard of life of the people. It has always been largely concerned with social legislation from the time of the Cross Act for the Housing of the Poor 1887, to the Money Lenders Act 1926, the Hire Purchase Act 1937, and the Adoption of Children Act 1939.

On the outbreak of war in 1939 the Society inaugurated the Citizens' Advice Bureaux in the London County Council area, which have proved of such value to vast numbers of citizens faced with the many unprecedented problems and perplexities of war conditions.

The Central Office of the Society carries out the administrative work, undertakes research into social problems, and administers special funds entrusted to it for relief and pensions. During the war its experience in this field has been utilised in the distribution of some of the large funds raised for the relief of war distress, including those of the British War Relief Society of U.S.A., the British War Refugees Fund and the Civilian War Distress Fund. One department is engaged in making inquiries as to agencies and individuals for the guidance of people to whom an appeal is made. This department has accumulated a considerable body of information as to the resources and administration of charitable institutions, and this is at the service of those who wish to make charitable gifts or bequests.

The family case work of the Society is carried out in its District Offices. Among the many kinds of help given are : Personal service in every sort of problem and predicament ; regular friendly visits to lonely old people and invalids ; pensions for disabled people and others not eligible for, or not able to subsist on, a State pension ; convalescent treatment and holidays for those who are ill or run down ; temporary allowances during illness ; arrangements for special training for the physically handicapped ; help with the provision of furniture, of equipment for a career and of surgical equipment of every kind.

**Relation to the State Services :** It is, of course, recognised that with the introduction of the National Insurance scheme and a national health service, the State will assume responsibility for supplying the basic needs of its citizens when they are unable to provide for themselves. Experience has proved however, that no State scheme can be designed to cover every contingency and there must always remain a vast number of emergency needs and exceptional cases which can only be helped from voluntary sources. However far-reaching the State social services may be in the future, it is certain that there will always remain an infinite variety of needs and problems calling for the services of a voluntary society.

One aspect of the work of the Charity Organisation Society is of especial importance with regard to post-war reconstruction, namely the training of social workers. The Society believes that, while certain natural qualities are essential, a full training in principles, methods and technique is necessary for an understanding of, and for dealing with, human and social problems. The Society provides both theoretical and practical training in family case work, and welcomes the ever-increasing number of students who are preparing for various forms of social work, both with voluntary and with statutory bodies.

**Finance :** The work of the Society is entirely dependent upon voluntary contributions. The administrative expenses are met by subscriptions. District Committees do not form relief funds but in each case in which financial help is required the money is raised separately, from sources upon which the client seems to have a claim and by individual appeals.

## Children's Country Holidays Fund (Inc.)

*18, Buckingham Street, Strand, London, W.C.2. Telephone: Temple Bar 3762.*

*President: The RT. HON. THE EARL OF ATHLONE, K.G., P.C., G.C.B., G.C.M.G., G.C.V.O., D.S.O.*

THE Children's Country Holidays Fund was founded in 1884 by the late Canon and Mrs. (later Dame Henrietta) Barnett, for the purpose of sending away during the school summer holiday, poor children who would not otherwise have a holiday in the country. It is under the patronage of H.M. The Queen.

In peacetime the work of selecting the children, collecting the contributions of the parents, seeing off the boys and girls from the main line stations and meeting them on their return, is carried out by the voluntary workers of London Committees in the different districts. These local committees vary in number yearly. The average is between 60 and 70.

The largest number of children sent away during one summer was 46,402 in 1912, while the greatest number in the years between the two wars was 33,919 in 1936. The total number to be sent to the country or to the seaside, over the period from 1884 to 1939 inclusive, was 1,563,128.

In the country, other voluntary workers (country correspondents) find reliable hostesses, meet the children, distribute them to their hostesses, look after their welfare while they are in the country and see them off at the end of the fortnight or month. The "C.C.s" also pay the hostesses on the receipt of cheques from the London honorary treasurers concerned.

The children are drawn mainly from the elementary schools and the parents contribute according to their means. These contributions are paid weekly, in small sums, to the London visitor and begin early in the year.

The C.C.H.F. is undenominational and non-political.

During this war the C.C.H.F. has been helping, on a small scale, those children specially recommended for a holiday by the school doctors, or by well-known organisations such as the Invalid Children's Aid Association or

the Charity Organisation Society. In addition it has found homes for the older "under-fives"—children passed by the special panel set up by the Ministry of Health for independent evacuation, but considered too near school age to be sent to a residential nursery.

The Children's Country Holidays Fund expects to resume its normal work after the end of the war in Europe, but it will probably be concerned mainly with children from the primary schools, *i.e.*, those aged from 5 to 11, instead of those from 5 to 14 as in pre-war days. Older boys and girls will probably go to camps or have other holidays provided by the various juvenile organisations interested in secondary school children.

The income of the C.C.H.F. is derived from the parents' contributions, public subscriptions and investments.

In May 1943, The Children's Fresh Air Mission, founded in 1882 and dealing with Holborn and Finsbury, became part of the C.C.H.F. Between 1882 and 1939 it had sent away 142,622 children.

## College of Midwives

57, Lower Belgrave Street, London, S.W.1. Telephone: Sloane 8313.

President: MISS E. M. PYE, Chevalier de la Légion d'Honneur.

THE College of Midwives, which is under the patronage of H.M. The Queen, is the professional organisation for midwives. It was founded in 1881 and was then known as the Midwives' Institute. Its objects are: To raise the efficiency and improve the status of midwives; to establish a centre of information for the public; to provide a good medical lending-library and club-room for friendly meetings; to arrange courses of medical lectures and to afford opportunities for friendly discussion on subjects connected with the profession; and the doing of all things to promote the efficiency, comfort and development of midwives.

Education has always been the key-note of the College. Its first meeting took the form of a medical lecture for midwives and nurses, and instruction to midwives has continued ever since. Important educational pioneer work undertaken by the College includes the organisation of instruction courses for midwife teachers. The College is approved by the Central Midwives Board as a recognised institution for giving lecture courses to pupil midwives. Summer Schools have been arranged in different parts of the country, the first being held in 1942 at Lady Margaret Hall, Oxford. Three more arranged for 1944 had to be cancelled because of transport difficulties, but it is hoped that Summer Schools will be held in 1945 at the University College, Bangor, Bristol University and London. During 1944 Midwife Teachers Conferences were held in Edinburgh and Birmingham, and it is hoped in future to hold one in the north and one in the south of England every year to discuss the country's midwifery teaching problems.

The College of Midwives was, before the war, affiliated to the International Federation of Midwives. It is hoped that when hostilities cease the International Federation of Midwives will be revived by a meeting in London similar to the International Conference held there in 1934 which was attended by delegates from many European countries.

The branches, of which there are 148 throughout the country, are an essential part of the College, for which and through which it exists. They take an active part in the education of midwives by means of post-graduate lectures, which form an important part of their programme.

Apart from legislative work, the College has taken an active share in administrative work on a national claim. The appointment of a Midwives' Salaries Committee has been obtained and two members serve on the Advisory Council of the Ministry of Labour and National Service for the Recruitment and Distribution of Nurses and Midwives. It has been recognised as a certifying body under the uniform rationing scheme and has gained concessions for the benefit of midwives. Many other problems of a national nature have been dealt with.

## Empire Rheumatism Council

*106, Finchley Road, London, N.W.3. Telephone : Hampstead 3318.*

*President: HIS ROYAL HIGHNESS THE DUKE OF GLOUCESTER,  
K.G., P.C., K.T., K.P.*

THE Empire Rheumatism Council was founded in 1936 to organise research throughout the British Empire into the causes and means of treatment of rheumatic disease. For some years previously (since the publication of the Ministry of Health Report 1924, exposed the serious incidence of rheumatic disease among the workers) there had been growing interest in the problems of rheumatism, and recognition that it is among the chief social plagues. Lord Horder (Chairman of the Council) who in his early days on the staff of St. Bartholomew's Hospital had come to this recognition, was the prime instigator of various efforts for remedy. The Royal College of Physicians appointed a Committee on Rheumatism which did valuable work. In 1936 that Committee agreed that a wide appeal to the general community was needed and it, therefore, formed the scientific nucleus of the Empire Rheumatism Council which was planned as a joint medical and lay organisation extending its scope to the whole British Empire.

At the close of 1937 excellent progress could be recorded. An organisation of great strength both on the scientific and administrative side had been built up. The late Sir Kingsley Wood, then Minister of Health, wrote, "The very important work of your Council has my wholehearted sympathy and support." An affiliated Council was founded in Canada and another projected in Australia. By propaganda world-wide attention was attracted. In the United Kingdom over 2,000 press articles were published and an extensive series of educational meetings held. Two research laboratories were founded in London.

In 1938 the Empire Rheumatism Council dispatched travelling Research fellows to Europe and North America to study systems of treatment abroad. In co-operation with the Admiralty Medical Services the Naval Research Foundation was instituted to investigate the causes of the incidence of acute

rheumatism in the training establishments of the Navy. Its work proved of great value. The outbreak of war inflicted a grave check on progress. One of the London laboratories was destroyed by enemy action and another taken over by the Emergency Medical Service. Much valuable research work was, however, carried out in various quarters and a new treatment centre established at the West London Hospital, which now deals with some thousands of patients yearly.

In 1941 was published *Rheumatism—A Plan for National Action*, by Lord Horder (in collaboration with the Empire Rheumatism Council). This was extensively and most favourably reviewed in the medical and lay press, was endorsed by the chief Public Health Committees of the kingdom, and seems bound to become the basis for a national plan of treatment. There followed later the official pledge of the Government that post-war health policy would provide "treatment appropriate to their needs" for all the community, including rheumatic sufferers.

At the close of 1944 the Empire Rheumatism Council considered that a good half of its task had been accomplished; the nation fully apprised of the necessity for checking the ravages of rheumatic disease; appropriate early treatment (which it is estimated would reduce those ravages by 50 per cent.) promised; and research into causative factors materially advanced. The tasks remaining are to carry research to its conclusion and to see that, by means of post-graduate and student education, the medical profession is equipped to staff efficiently the national chain of treatment centres.

## Eugenics Society

69, Eccleston Square, London, S.W.1. Telephone: Victoria 2091.

Honorary President: The RT. HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.

THE Eugenics Society was founded in 1908. In 1912 it successfully called an International Congress of Eugenics in London.

The general aim of the Society is to improve human racial qualities by rational selection, *i.e.*, by encouraging natural increase among well-endowed persons, and discouraging propagation among inferior and sub-normal stocks. The ethical basis of this object rests on man's duty to his neighbours and to posterity, to provide the best possible environmental condition as well as the best physical and mental human endowments. The scientific basis is the study of transmissible biological characteristics.

As a preliminary step the Society aims at creating in the community a "eugenic conscience" by educating youth in the principles of biology, and by developing in everyone an appreciation of the effects of their actions on future generations. This conscience will influence the attitude of both the individual and the community towards marriage and parenthood.

The two main aspects of this work are scientific study and social practice. The former is necessary to give precise knowledge of the part played by heredity with regard to physical and mental make-up, so as to render possible the formulation of eugenic policies which will successfully influence fertility. The Society considers the following subjects to be specially in need of further

investigation: Human qualities and defects; population problems; the "social problem group" (as designated by the Mental Deficiency (Wood) Committee, 1930); family records; contraceptive methods; race mixture; migration; fertility and sub-fertility; artificial insemination; economic and social policies affecting fertility.

With regard to social practice, the Society has a three-fold task: To ascertain the rate of reproduction of the different social elements in the community; to examine the distribution of the eugenically valuable hereditary characteristics among the community; and to discover what are the deterrents to parenthood operative in those groups considered to be eugenically valuable. These obstacles affect three stages in the individual's life, *i.e.*, approaching marriage, child-bearing and child-rearing. To meet these problems the Society favours early and fertile marriage in professions where superior qualities are demanded, reduction in costs of maternity services, economic facilities for employed women who wish to have children, and social measures to lower the expense and reduce the inconveniences of child-rearing. The Society also favours family allowances, rebate on taxation for people with children, assistance with educational expenses, planning of houses to accommodate larger families, and the voluntary exchange of health certificates by people before marriage. On the negative side, it suggests voluntary restriction of multiplication amongst those suffering from hereditary disabilities and infirmities, to be achieved by the promulgation of a widespread eugenic conscience, and of knowledge of birth control. This also involves consideration of sterilisation, segregation and termination of pregnancy in cases of persons with transmissible diseases.

In general, the Society aims at replacing the present generation by children who are deliberately conceived in the full light of all known medical, social and genetic factors. It favours the planned as against the unplanned family; and it wants to see the community so organised that its best citizens will feel eager to give full expression to the instincts of parenthood.

The Society has a reference library, a quarterly review, and an information service for Fellows and Members. It also holds Members' meetings.

## Food Education Society

*Gordon House, 29, Gordon Square, London, W.C.1. Telephone: Euston 3151.*

*President: The RT. HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.*

THE Food Education Society, formed in 1908, was incorporated in 1919. In 1942 it was reorganised and a number of authorities on nutrition came on to the Consultative Scientific Council. Its organisation at present comprises an Executive Council and three permanent Committees, namely, General Purposes; Press and Publicity; and Finance.

The objects of the Society are to raise the standard of national health and to reduce preventable disease by promoting knowledge in the choice and preparation of food, and by developing an appreciation of the inter-relationship between soil fertility, food quality and human health.

The Society's activities are guided by the principles set out in a manifesto issued after its reorganisation in 1942. This demands, primarily, a

sufficiency of good food for everyone. It is estimated that approximately one-third of the population of Great Britain exists on an inadequate diet, and that to prevent sickness the population should have the right kind of, as well as sufficient, food. In this respect it is maintained that the National Health Insurance Act has failed in that it has not dealt with nutrition, which is the root of health. This provision should be one of the chief Government services, and more efforts should be made to popularise the use of salads and vegetables in schools, hospitals, canteens and restaurants. The need is stressed for new legislation to ensure that every container of prepared food shall bear a statement of the composition of its contents. Similarly the Government should possess powers to deal with food-advertising, and especially to prevent the misrepresentation of the value and effects claimed for food preparations. The manifesto points out the serious loss suffered by the soil when organic waste from residential areas is destroyed or dumped into the sea instead of being used for humus. Finally, it is maintained that nothing should be allowed to interfere with the reform of our food supply and with the institution of a real system of preventive medicine, so that the health and nutrition of the nation may be developed and thereby the physical, mental and moral quality of its people.

In pursuit of these principles the activities of the Society include conferences, publications, lectures and the supply of information to members and the public. Among the conferences already held and for which proceedings have been published are: *The Soil and Methods of Increasing its Fertility*; *Industrial Canteen Catering*; and *Hospital Meals*.

The Society provides a platform for the discussion of matters of current interest in connection with food, feeding, nutrition and dietetics.

## Girl Guides Association

17-19, Buckingham Palace Road, London, S.W.1.

Telephone: Victoria 6001.

Founder: The Late LORD BADEN-POWELL OF GILWELL, O.M., G.C.M.G., G.C.V.O., K.C.B., LL.D.

President: HER ROYAL HIGHNESS THE PRINCESS ROYAL.

THE Girl Guides Association was founded in 1909, and was granted a Royal Charter in 1923. The management is vested in a Council which carries out its policy through an Executive Committee which administers the movement throughout the Empire. As far as possible administration is decentralised and Commissioners are appointed by the Executive Committee to act as its representatives in countries, provinces and counties. Guiding is international and non-political. In 1939, 32 countries were members of the World Association of Girl Guides and Girl Scouts. Nearly a million and a half active members are enrolled. About half these are in the British Empire and the other half in foreign countries.

The aim of the Association is the promotion of good citizenship through individual character training to help full physical, mental and spiritual development of the girls.

Membership is dependent upon the acceptance of the threefold Promise : " I promise on my honour that I will do my best ; to do my duty to God and the King ; to help other people at all times ; to obey the Guide Law." The Law conveys a code of living, which includes honour, loyalty, helpfulness, friendliness, courtesy, cheerfulness in difficulties, thrift and cleanliness.

Guides are divided into the following age groups : Brownies (aged 7½-11) ; Guides (11-16) ; Rangers (16-21) ; Cadets (16 and upwards in training as Guiders) ; Guiders (adult leaders).

Guiding activities are very varied but the four definite objectives of training, from Brownie to Ranger are : Development of character and intelligence through games and tests, and a sound self-discipline based on the rules of life set out in the Law and the Promise ; the acquiring of skill in some pursuit or craft, so that the joy and worth of creative activity may be experienced ; the achievement of physical health and fitness through camping, outdoor games and the practise of simple health rules ; opportunities to experience comradeship and service for others through daily good turns, organised public service, and by being a member of a world-wide fellowship, of which the uniform and trefoil badge is the visible reminder. All the tests are carefully planned to reach one or more of these objectives, and Brownies and Guides win a badge, and Rangers an armband or certificate when they have passed them. " Laugh while you work " was one of the founder's maxims, so this has been made a characteristic of Guide methods ; singing, dancing, games and stories, all form part of the weekly programme.

The following principles underlie the training : True and practised loyalty to God is the foundation stone of guiding ; guiding is not denominational and every Guide and Ranger is encouraged to be a loyal member of the religious body to which she belongs ; training as a member of a self-governing community is essential to the full development of the individual. The patrol system is the corner-stone of Guide training. The company is run by the Guides themselves through their patrol-leaders, who represent them at the " Court of Honour," the governing body of the company. Qualities of character, making for good citizenship, are best developed by living in the open and learning from nature. Guiding is essentially an outdoor movement and camping, hiking and woodcraft form an important part of the training. The aim of every Guide and Ranger company is to have its own camp in order that they may put into practice all that guiding has taught them throughout the year.

During the war the value of Guide training has been proved more fully than ever before. Many Guiders have held posts of great responsibility in the women's services and other fields of national service, and the young people themselves have never tired in their determination to pull their weight. They have tackled every kind of job from the humblest form of salvage to those requiring spectacular heroism. They have also proved the value of the patrol system and many companies would have had to close down had not the patrol-leaders been able to carry on when their Guider was called up for work elsewhere. Stories of Guides in the liberated countries are coming through and it is known that they have carried on quietly during the period of occupation and have great plans afoot for future meetings with Guides in this and other countries.



# Howard League for Penal Reform

*Parliament Mansions, Abbey Orchard Street, London, S.W.1.*

*Telephone: Abbey 3689.*

*President:* The RT. HON. LORD MAMHEAD OF EXETER.

THE Howard League and its parent society the Howard Association (founded in 1866) were named in honour of John Howard the prison reformer. The objects of the League include all forms of penal and prison reform designed to prevent crime and delinquency by wise and humane methods of dealing with law-breakers. It has always worked for the abolition of purely repressive punishments—the death penalty, flogging, the birching of child offenders, solitary confinement, the old silent-system and degrading customs such as the wearing of the broad arrow and the convict crop.

The Howard Association first drew the Home Office's attention to the probation system, as practised in Massachusetts, U.S.A. 70 years ago, and from that time onward pressed for a Probation Act in this country. Similarly the League has consistently worked for the gradual emptying of the prisons by providing other treatment for mental defectives, the feeble-minded, epileptics and young offenders.

**Methods :** The League works through public meetings and conferences ; by supplying speakers to meetings of other societies ; by investigation and report on penal experiments at home and abroad (*e.g.* the Belgian and Portuguese Observation Centre for Young Offenders, the Norwegian Child Welfare Councils, the Youth Correction Act of U.S.A., the Soviet self-governing prison at Bolshevo and many others) ; by the publication of the *Howard Journal*, its official organ, which includes articles by experts in penal administration and one in each number by a prisoner ; by publishing pamphlets ; by maintaining the John Howard Library of Criminal Law and Penology (reference and lending—1,500 volumes) ; and by working to secure legislation and the keeping of a watchful eye on penal administration through an all-party Penal Reform Group in the House of Commons. This Group was directly responsible for the Poor Prisoners' Defence Act 1930, and the Appeals (Summary Jurisdiction) Act 1933, and also promoted a Children Bill 1930, foreshadowing the Children and Young Persons Act 1933, and an Abolition of Corporal Punishment Bill 1930. It also works by direct approach to the Home Office to urge reforms *e.g.* the Departmental Committee on Corporal Punishment (which after inquiry unanimously recommended abolition), appointed largely as a result of a Howard League Memorial signed by distinguished men and women in all departments of art, literature, science and politics ; through the promotion of reforms directly inside the prison (*e.g.* the League raised the funds for the first earnings scheme at Wakefield prison which scheme now covers all the prisons and is at present providing funds for wireless in selected prisons and some correspondence courses, in the belief that in this way, more constructive educational and recreational work will be secured) ; by giving evidence and making proposals for reform before every Royal Commission

and departmental committee on penal questions (*e.g.* Select Committee on Capital Punishment, Legal Aid Committee, Justices Clerks Committee, Social Services Committee, Royal Commission on Police Powers); by working in the Dominions through affiliated societies such as the Howard League of New Zealand, the John Howard Society of British Columbia and others in S. Africa, Canada and Australia; by urging the Colonial Office to improve penal methods in overseas dependencies, in which connection the League's first efforts succeeded in securing the establishment of a Standing Advisory Committee on Penal Administration (recently reconstituted as a Social Welfare Committee) at the Colonial Office.

The League hopes to secure more fundamental reforms after the war of which the following are the main principles: The abolition of the death penalty and of corporal punishment; the abolition of imprisonment of all young persons under 21 and the substitution of new methods *e.g.* State hostels, Saturday afternoon fatigue duties, etc.; the reform of Magistrates Courts by (a) the appointment of a national service of full-time clerks with retiring age, (b) the insistence on some training and a retiring age of 65 for J.P.'s, (c) effective legal aid from the outset for poor prisoners; the expert medical examination, physical and psychological, of offenders after conviction and before sentence; the extension of the probation system by the appointment of fully trained probation officers; restitution as a normal part of the penalty for crimes of dishonesty or malicious damage; the abolition of the old "fortress" prison and development of camps and "minimum security" prisons and "cottage home" establishments for women; improved medical services in prison, including provision of psycho-therapy where necessary or desirable; educational services, using voluntary teachers and lecturers as well as paid staff, as an integral part of the prison regime, with the reorganisation of prison industries on an economic basis, full wages to prisoners to be divided between the State (to cover maintenance and supervision), the prisoner and his dependants; non-penal colonies for apparently incorrigible offenders, with the maximum of freedom and self-government within such colonies.

## Imperial Cancer Research Fund

*c/o The Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.2.  
Telephone: Mill Hill 3544.*

**President:** The RT. HON. THE EARL OF HALIFAX, K.G., P.C.,  
G.C.S.I., G.C.I.E.

THE Imperial Cancer Research Fund, incorporated by Royal Charter, 1939, was founded in 1902 under the direction of the Royal College of Physicians of London and the Royal College of Surgeons of England. It is under the patronage of H.M. The King.

Its earliest work was carried out in two rooms of the old Examination Hall on the Victoria Embankment but as the work of the Fund grew and experimental investigations on cancer began to extend so widely, it became

essential for the Fund to find new laboratories, and after a succession of moves a block of modern laboratories was built at Mill Hill where provision was made for every kind of investigation likely to advance the knowledge of cancer. This building was opened in 1939 and since then has been in continuous use for systematic investigations on cancer. It contains up-to-date laboratories with accessory accommodation and a reference library.

Stated briefly, the objects of the Fund are as follows: To make and promote investigations into all matters connected with or bearing on the causes, prevention, treatment and cure of cancer; to encourage researches on the subject of cancer within the British Empire; to assist in the development of cancer research in hospitals and institutions approved by the Council; and generally to provide means for systematic investigation into the causes, prevention, treatment, and cure of cancer.

The Mill Hill laboratories are staffed by a Director and a team of six other medical men or scientists. In addition there are from time to time visiting research workers from other laboratories in this country or other parts of the world.

The Governors of the Fund include representatives of Government departments of the Medical Research Council, of the Royal Society and of medical and veterinary corporations, prominent benefactors and people who have rendered special services to the Fund. The ordinary affairs of the Fund are conducted by a Council consisting of the Presidents and other representatives of the Royal Colleges of Physicians and Surgeons, the Honorary Treasurer, and representatives of the Royal Society, the Medical Research Council and the Royal Veterinary College and Hospital.

The Central Office of the Fund is in the Royal College of Surgeons of England, where meetings of the Council and Committees are held. The present Director of the Fund, Dr. W. E. Gye, is Professor of Experimental Pathology in the Royal College of Surgeons, and two lectures are given each year in the College by members of the Scientific Staff of the Fund.

The Fund publishes an Annual Report which includes a résumé of the research work carried out, and has from time to time issued scientific reports. Members of the staff contribute several papers each year to medical and scientific journals.

The Fund receives no income from any official source and relies entirely on voluntary contributions. It has been most fortunate in its benefactors, some of whose names are commemorated by Fellowships or special funds.

## Industrial Welfare Society

*14, Hobart Place, London, S.W.1. Telephone: Sloane 6182.*

*Director: The REVEREND ROBERT R. HYDE, M.V.O.*

THE Industrial Welfare Society which is under the patronage of H.M. The King, was founded in 1918, as the result of experience gained in the last war, to act as a focus for welfare work in industry, and to develop on a voluntary basis activities to promote the safety, health, security and well-being of the workpeople. The Society aims at preserving this voluntary system, for it is not only in keeping with the best traditions of the country, but offers the greatest scope for progress and individual development.

This was officially recognised by a memorandum on welfare work submitted to the Balfour Committee on Industry and Trade by the Home Office Factory Department, which said : " State intervention can only go a very small way in promoting welfare work. . . . Theoretically the State could impose on all firms of a certain size the duty of creating a definite welfare organisation, but not only could this not be expected to achieve the same material results as a voluntarily established organisation, but it would lack what is even more important, the spirit by which the organisation should be animated."

Local and trade conditions vary so greatly in this country that it would be impossible to lay down a single welfare scheme for industry. The problems of no two firms are alike, but it has been found that from the pooled experience of member firms each can draw what is most applicable to its particular circumstances. By acting as a central clearing-house of information and by close contact with experience in industry, the Society has maintained the flexibility of the movement, and during the 24 years of its existence has built up a valuable store of knowledge. Questions of hours and wages, which are matters of negotiation between the federations and the trade unions, do not come within the scope of the Society's work, but it is concerned with all aspects of the human side of industry. By maintaining the voluntary character of the movement the fullest scope is given to practical experiment, and it is on the basis of this pioneering that the later legislation of the Factories Acts has been made possible.

Membership of the Society entitles a firm to visits by the staff for consultation on the introduction and development of welfare schemes, and to the use of the information services on any matters within the scope of the following subjects. Inquiries on specific problems are welcomed. Service to members is given under the following headings :

**Welfare and Personnel :** Organisation of welfare and personnel work ; selection, transfer and promotion of labour ; the keeping of records and statistics.

A panel of candidates qualified for welfare and personnel posts is maintained.

**Health :** The organisation of medical and first-aid services in the factory ; advice on planning and equipment, costs of maintenance of ambulance and first-aid rooms ; dental measures to prevent disease and improve general health ; reduction of fatigue ; rest pauses ; posture ; rehabilitation and light work for the injured ; facilities for convalescence.

In dealing with health questions the Society is guided by its Advisory Medical Committee, composed of leading industrial medical officers.

**Working Conditions :** Heating, lighting, ventilation, sanitation, seating ; cloak-rooms and rest-rooms ; advice on planning and equipment ; provision and maintenance of protective clothing.

**Education and Technical Training :** Apprenticeship schemes ; technical instruction ; training of juveniles ; works schools and continued education ; adult education and development of cultural activities.

**Accident Prevention :** Safety and protective devices ; training in safety methods ; safety committees ; accident prevention campaigns ; records ; films ; speakers.

**Canteens and Communal Feeding :** Organisation and extension of

meal services and advice on planning; management; staffing; control; equipment; menus; wartime problems.

**Co-operation :** Organisation and running of works councils and committees; suggestion schemes; employee handbooks; works and staff magazines; layout; the arrangement of conferences of editors.

**Works Funds :** Inauguration of sickness and benevolent funds, pension, superannuation and savings schemes; drafting of rules and constitutions.

**Social and Recreation Activities :** Organisation of sports and social clubs; drafting of rules; advice on planning of sports grounds and pavilions; indoor hobbies; camps and holiday homes; works libraries.

**General :** Information and guidance given by the Society on all welfare problems raised by the Factories Act; Regulations of the Factory and Welfare Department; A.R.P.; rating; fines; deductions from wages; performing-rights, royalties and entertainment tax; the establishment of pension and superannuation schemes; club constitutions; works funds.

*The benefits of membership also include :*

**Appointments Panel :** Access to the Society's panel of candidates qualified for appointments as welfare supervisors, employment managers, works doctors, nurses, canteen managers, etc.

**Conferences :** Notice of the Annual Conference and special conferences on subjects of current interest; notice of lecture courses arranged from time to time in different centres on welfare and personnel work, and industrial law.

**Publications :** All publications of the Society, including the bi-monthly journal, *Industrial Welfare and Personnel Management*; bi-monthly, *Confidential Bulletin* of information; also occasional booklets, dealing with some phase of welfare work.

**Library :** Use of the Society's loan library; the supply of a catalogue by the librarian and his advice on reading; reviews of new books in the *Journal*; the use of the library for study.

**Speakers :** Speakers on any aspect of welfare and personnel work to address workers or special groups, such as foremen and safety committees.

Particulars of subscription rates may be obtained from the Secretary.

## London School of Hygiene and Tropical Medicine

*Keppel Street, London, W.C.1. Telephone: Museum 3041.*

*Chairman of the Board of Management: SIR GEORGE ELLISTON, M.C., M.A., D.L., J.P., M.P.*

THE London School of Hygiene and Tropical Medicine can be said to have its present composition from the amalgamation of the School of Hygiene (as envisaged by the Reports of the Earl of Athlone's Committee in 1921), the School of Tropical Medicine (formed by the Seamen's Hospital Society in 1899 and associated with Sir Patrick Manson) and the Ross Institute at Putney (founded in 1926). This took effect from January, 1934.

Within the scope of the work carried out is "the maintenance of health and the prevention of disease not only in temperate but in tropical and arctic climates." With this object in view the School has eight main departments, dealing with bacteriology and immunology; biochemistry and chemistry as applied to hygiene; clinical tropical medicine; epidemiology and vital statistics; parasitology; entomology; public health (which includes the application of physiology and psychology to problems of industry); and the Ross Institute of Tropical Hygiene. In addition there is the Institute of Agricultural Parasitology, situated on the outskirts of St. Albans.

Post-graduate diploma courses in bacteriology, epidemiology and statistical methods, public health, and tropical medicine and hygiene are given annually, whilst the School also makes provision for an Academic Post-Graduate Diploma in Psychology and Physiology as applied to industry. A course is arranged to enable qualified medical practitioners to obtain recognition from the Board of Education under the Mental Deficiency Acts. The School also holds courses for laymen on the control of malaria and one on tropical hygiene. Facilities are provided for candidates to obtain post-graduate degrees, *e.g.* M.D. in Hygiene and M.D. in Tropical Hygiene, as well as to prepare for the degrees of M.Sc., Ph.D., and D.Sc.

Scholarships and prizes are offered to enable students to proceed with research in various branches of the School. They vary in value, and the "Wandsworth" scholarship of £350 per annum founded by the late Lord Wandsworth is available for medical research either at home or overseas.

The library of the School, essentially used for reference purposes, has increased since its foundation in 1921, by the incorporation of smaller libraries, including that of the Ross Institute. It now houses about 57,000 volumes and unbound pamphlets, covering the main topics taught at the school, and contains a valuable collection of literature on tropical diseases and hygiene, dating from the 17th-18th centuries, and the Reece Collection on smallpox and vaccination.

The Museum, which occupies three floors at the front of the building, is arranged to show various aspects of the work of the School and is meant to supplement the work by graphic representation. Visitors, both medical and lay, are welcomed.

During the period of hostilities the general teaching of the School has been postponed, and work has been devoted to the giving of special courses in tropical medicine and parasitology for medical officers of the British and Allied forces, and to other work of national importance.

## Marriage Guidance Council

78, Duke Street, Grosvenor Square, London, W.1. Telephone: Mayfair 6787.  
President: The RT. HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.

THE Council, originally formed in 1938, was reconstituted in 1942 as the spearhead of a new branch of social and personal service. Its aim is to promote successful marriage and parenthood, with a view to safe-guarding

and strengthening healthy family life. It proposes to do this in three ways.

Firstly, by education. A great deal of marriage breakdown could be averted if young people were adequately prepared for family living. The natural counterpart of sex education in childhood is marriage preparation in late adolescence. Right attitudes can be inculcated and wrong choices avoided. This education can be undertaken in two ways, one, by public talks and lectures to give general guidance to those approaching mate selection, and two, by private counselling to give more detailed instruction to engaged couples.

Education is also required by those already married and by specialist groups whose calling requires them to deal with marriage difficulties. The Council undertakes to deal with all these needs. In addition to the work done by its lecturers and consultants, it makes wide use of books and pamphlet literature.

Secondly, the Council undertakes remedial work in marriage difficulties. The London Marriage Guidance Centre has laid down a pattern for this service. Guidance on marriage problems of all kinds—medical, psychological, ethical and spiritual, social and legal—is given by a team of qualified and experienced consultants. The approach is personal, sympathetic, and strictly confidential. Simple difficulties are cleared up but no technical treatment is given at the Centre. The work is on a short contact basis. The aim is to diagnose the trouble and to refer where necessary to the appropriate private practitioner or remedial agency.

The need for provincial centres is great, and they are being established in the larger towns by the Council's branches. In smaller communities, the establishment of a marriage guidance panel is found better, requiring simpler organisation and ensuring greater privacy. These centres and panels seek to co-operate cordially with local private practitioners and social agencies, to supplement their work and not to usurp it.

Thirdly, the Council encourages all measures designed to provide a more secure social and economic basis for family life, by supporting reforms, both national and local, where they are deemed necessary.

Membership of the Council is open, at a low annual subscription, to all who approve its aims and objects. At the General Meeting members elect annually the nucleus of the Executive Committee, which consists of 15 people including the officers of the Council. In addition, this Committee includes a representative of each branch of the Council. These branches are established in many areas of the country. They are completely autonomous in matters of organisation but are expected to accept the aims and principles set out in the Memorandum of the national body.

The Council is anxious, as it has opportunity, to encourage scientific research on marriage and to make its experience available to those who can derive benefit from it.

It is anticipated that the need and the opportunity for marriage guidance will increase in the years after the war. Plans have, therefore, been made for a considerable extension of the Council's activities. It is hoped to establish many new branches and to set up further marriage guidance centres and panels. A great increase and expansion of educational work is proposed as the surest preventive against marriage breakdown, especially through institutions catering for young people in the late adolescent period. The widespread circulation is envisaged of sound literature on marriage to

replace some of the inferior material at present on the market. Efforts are also being made to encourage the close and more integrated co-operation of the many bodies serving the welfare of the family, with a view to presenting a more united front in their common task.

Further information may be obtained from the Secretary.

# National Association of Girls' Clubs and Mixed Clubs

*Hamilton House, Bidborough Street, London, W.C.1.*

*Telephone: Euston 2464.*

*President: HER GRACE THE DUCHESS OF BUCCLEUCH.*

THE National Association of Girls' Clubs and Mixed Clubs exists to develop and strengthen club work by training leaders and enlarging club programmes. Through county and county borough associations it works, in close co-operation with voluntary organisations and statutory authorities, to promote a variety of clubs, self-governing and individual in character, suited to the locality and supported by local interest; to keep before Government departments, local authorities and the general public the welfare of young people; and to act as a central advice bureau for clubs.

During 1943-44, 1,800 clubs were affiliated, with a total membership of 97,500 of whom 16,300 were under 14 years old; 70,000 between 14 and 20; and 11,200 over 20. Clubs can affiliate as soon as they have 12 members and comply with certain conditions. Many clubs include boys as well as girls.

The club members have their own national council and work through local members' councils, thus playing a responsible part in the development of club work. The members are being trained to take increasing responsibility in the management of their own clubs. They, and the general public, have been asked to raise £100,000 during the next three years to support a national and international centre at Avon Tyrrell, Hampshire; a London Club House with residential and non-residential accommodation; and a chain of holiday houses and camp sites throughout the British Isles.

The Education Department of the National Association gives advice on club programmes and new educational techniques and arranges demonstration week-ends of an educational nature.

The National Association administers bursaries for youth-leadership training, through a fund given by the Carnegie United Kingdom Trust. The bursaries enable club members who have shown outstanding qualities of leadership to take a professional course in youth leadership, and they are also available to other first-rate candidates who would be debarred for financial reasons from taking the training.

The N.A.G.C. and M.C. has three forms of training: A professional youth-leadership training course, which includes a Social Science Certificate or Diploma, together with from 6 to 12 months' specific training in



youth leadership ; a part-time course which may be taken by people already in work, over a period of 18 months ; and a three or six months' course designed for people between 25 and 40 who have relevant experience in other fields of social work. This will be developed into a one-year course in the post-war period. Bursaries are also available for the part-time course, and the three and six months' courses.

The National Association, in addition to its own voluntary funds, is grant-aided by the Ministry of Education under the Service of Youth Scheme.

Further information may be obtained from the Organising Secretary.

## National Association of Boys' Clubs

*17, Bedford Square, London, W.C.1. Telephone: Museum 5358.*

*President: HIS ROYAL HIGHNESS THE DUKE OF GLOUCESTER,  
K.G., P.C., K.T., K.P.*

THE health policy of the National Association of Boys' Clubs is physical, mental and moral fitness engendered by a positive attitude towards life. Of these three inseparable aspects, physical fitness is the easiest to assess, although no yardstick is infallible. The N.A.B.C. itself had a series of tests designed to test physical fitness, but in the national interest it decided to adopt those recommended by the pre-Service organisations. A fitness Trophy is awarded to clubs carrying out certain activities and entering at least 75 per cent. of their membership for tests, which are the same as those laid down by the pre-Service organisations. It is realised that training is necessary for this, and the majority of clubs have gymnasias and playing fields (often far from ideal in crowded cities) where fitness is pleasurably developed. Camps have always been a feature ; but in wartime their scope is limited, chiefly because of the extremely short holidays granted to boys in industry.

Each club aims at having a doctor who will carry out medical inspections and attend, if possible, at boxing matches, etc. A few doctors are sufficiently interested to follow their boys to camp. It is hoped that, in the near future, club leaders will be privileged to see the routine school medical inspection cards of their members. Indeed, the club might well be used to "rehabilitate" those boys who have been incapacitated by injury or disease. A strong case for convalescent homes for adolescents can be stated. In all aspects of health, the Association wishes to work in collaboration with the statutory health authorities and not to duplicate services.

Adolescence, like all transition periods, presents difficulties of its own and it is hoped that these will be overcome by the introduction of a comprehensive medical service. It is held that adolescents should have the opportunity of first-class treatment and first-class convalescence or rehabilitation. The treatment granted up to age 14, by virtue of the receipt of full-time education, should be extended until full benefits are obtainable either as a panel patient or as a member of an approved society. This in particular applies to treatment for defects of the eyes and teeth.

The attainment of mental and moral health is the leader's chief concern. The club is essentially a centre of recreation, in which the positive attitude again plays the leading rôle. In addition to organised outside games, the club provides indoor activities such as chess, draughts, billiards, ping-pong and cultural activities such as drama, music and handicrafts, and also arranges lectures and classes for "informal" education. A healthy attitude towards sexual problems is created through the imparting of full information by the club leader (often with expert guidance), so that the boy can realise the significance of his powers and sublimate for his future well-being any temporary disorders.

The Association desires to develop hale and hearty boys ; to co-operate in every way possible with parents and civic authorities ; to inspire boys with the conviction that good health is an asset attainable by their own corporate efforts ; and to see that any who are ill or who fall ill are restored to complete health.

## National Baby Welfare Council

*29, Gordon Square, London, W.C.1. Telephone: Euston 2595.*

*President: The RT. HON. WINSTON S. CHURCHILL, P.C., C.H., F.R.S., M.P.*

THE National Baby Welfare Council is under the patronage of H.M. Queen Mary and includes amongst its Vice-Presidents many distinguished names. The Chairman of the Council is Lord Forrester, and its affairs are conducted by an Executive Committee under the chairmanship of Dr. D. H. Geffen, Medical Officer of Health to St. Pancras and a member of the Minister of Health's Advisory Committee on Mothers and Children.

The National Baby Welfare Council (as the National Baby Week Council) was formed during the last war, the circumstances arising from that calamity claiming the nation's better attention to its babies and children. Since 1917, when the first National Baby Week was held, the Council has laboured continuously to further the welfare of mothers and children by promoting a sound public opinion in favour of maternity and child welfare. Over a period of years the Council's propaganda work expanded and developed in so many directions (not only in this country but throughout the Empire) that the name "National Baby Week" implied too narrow an idea of the Council's many activities, and different work was called for to meet the needs of mothers and little children in the present war conditions. It was, therefore, considered that under the broader title of National Baby Welfare Council, the Council would be better able to continue and expand its work and develop its service to the nation.

Its objects and aims are : The promotion of maternal and child welfare on a national and imperial basis by every suitable means of public education and by approach to central and local governmental bodies ; the study and prevention of maternal and infant ill-health and mortality ; the dissemination of information relating to parental and family welfare ; and the achieve-

ment of closer relationship, by affiliation or otherwise, of those organisations engaged or interested in the various aspects of maternal and child welfare. The methods by which these are achieved include the preparation and distribution of publications, the arrangement of lectures, film displays, exhibitions, addresses, imperial and national competitions, broadcast talks, the annual celebration of "National Baby Week" from July 1st to 7th, the general education in maternal and child welfare, the issue of *Mother and Child*, the official organ of the Council, the supply of authoritative information and articles to the press, the production of films, and the collection of statistics and reports bearing on maternal and child welfare.

The Council's services are extended overseas by the provision of propaganda and instructional leaflets in connection with mothers and children ; through correspondents throughout the world ; and by the holding of an Imperial Baby Week Challenge Shield Competition in which the Shield is awarded annually for the best Baby Week campaign held in any part of the British Empire, exclusive of the United Kingdom for which there are other trophies.

The official organ of the Council is *Mother and Child*, the policy of which is to give publicity to all matters concerning the health and welfare of mothers and children, not only in the United Kingdom but throughout the Dominions and the British Colonial Empire and, in fact, throughout the world. The object of the editorial board, under the chairmanship of Dr. E. H. R. Smithard, is publicity to improve the health and welfare of women and children, and it is the desire of the National Baby Welfare Council that the journal should speak in such tones of truth and conviction that its voice may reach the four corners of the earth.

## National Birthday Trust Fund (Safer Motherhood)

57, Lower Belgrave Street, London, S.W.1. Telephone: Sloane 5076.

Chairman: LOUIS NICHOLAS.

THE National Birthday Trust Fund was founded in 1928 to carry out activities for the extension of maternity services, and especially those likely to bring about the reduction of maternal mortality, morbidity and suffering. Some idea of the work of the organisation may be obtained from the following particulars of work carried out during the period immediately before the war.

Substantial grants have been made to help many hospitals with maternity branches.

A permanent headquarters has been provided and maintained in London for the College of Midwives, the Queen's Institute of District Nursing and the Joint Council of Midwifery (dissolved in 1939). An inquiry has been carried out through the Royal College of Obstetricians and Gynaecologists to discover a safe and satisfactory method of relieving pain in child-birth. Gas-and-air analgesia by the Minnitt or similar apparatus was found to be a satisfactory method, as approved by the Central Midwives' Board for use

by midwives acting without medical supervision and the N.B.T.F. is now helping to provide these machines for this system to hospitals and Nursing Associations.

An experiment in the effect of improved nutrition upon mothers and their babies was undertaken in the Special Areas, and grants amounting to £19,000 were allocated by the Government to assist the Fund in this work. A Research Committee was set up, upon which two members were nominated to serve by the Medical Research Council. Over 21,000 expectant mothers were provided with extra nourishment. Their death rate was only 1.57 per 1,000 total births. Although the national maternal mortality during this period fell from 4.41 to 3.13 it was still much higher outside the experimental group. A paper upon this experiment to discover the effect of vitamin supplement to expectant mothers upon their own health and the health of their babies, was published in the *Lancet* of February 1944, by Dr. Margaret Balfour, C.B.E., M.B., F.R.C.O.G., who is in charge of the medical record taking side of the scheme.

Experiments relating to the value of certain disinfectants were carried out in the Rhondda Valley, where a special scheme of medical care for mothers was instituted for three years, with very good results. Six scholarships have been provided for candidates for the Midwife Teachers' Examination. A Samaritan Fund for necessitous expectant mothers has been maintained, and over 600 parcels of blankets were distributed in 1938 to expectant mothers in the Special Areas. The latest venture of the Fund is being made in co-operation with Queen Charlotte's Maternity Hospital, where a human-milk bureau was opened in 1939, through which means the lives of many delicate babies are being saved.

A chief aim has been the raising of the status of the midwifery profession, which required an Act of Parliament. With this object in view the Joint Council of Midwifery was set up in 1934 at the request of the N.B.T.F. This Council, working at the headquarters of the Fund and sharing its staff, produced in 1935 an agreed Report on the reform of the midwifery profession. This was accepted by the Government and provided the basis for the Midwives Act of 1936.

The Joint Council then began to consider the problem of non-therapeutic abortion. An inquiry was carried out into the relation between abortion and maternal mortality in 20 districts and six hospitals, and an Interim Report was issued embodying this information. This Report was submitted to the Inter-departmental Committee which was subsequently set up by the Government and on which eight members of the Joint Council were invited to serve.

The Joint Council of Midwifery was dissolved in 1939, and is not likely to be reconstituted after the war. The Research Committee is still in existence and the National Birthday Trust Fund co-operates with it, with the research workers of Queen Charlotte's Maternity Hospital, and with other organisations (including the College of Midwives and the Queen's Institute of District Nursing) in continuing research into maternal and neo-natal mortality and morbidity, *i.e.* death and sickness during the first 28 days of life.

Large new donations have recently been received by the N.B.T.F. and a comprehensive programme of research is now being worked out. Inquiries should be sent to the Secretary.

# National Council for Maternity and Child Welfare

*Carnegie House, 117, Piccadilly, London, W.1. Telephone: Grosvenor 1420.*  
*Chairman: DAME LOUISE McILROY, D.B.E., LL.D., M.D., F.R.C.P.*

THE National Council for Maternity and Child Welfare was incorporated in 1919. Its objects are: To promote the development of the welfare of mothers and children; to provide a central bureau of information on subjects connected with maternal and child welfare, and to maintain a library for the use of students and other workers concerned; to organise popular instruction through exhibitions, museums, lectures, demonstrations, and loan of teaching appliances; to arrange conferences and congresses of authorities and organisations concerned with maternal and child welfare; to establish in foreign countries and British dominions overseas, local councils or committees to further any or all of the above objects.

The Council has 19 constituent societies and it affords opportunity for the discussion of questions concerning the welfare of mothers and children. This is carried on through group committees and small conferences. A large conference is organised annually on behalf of the Council by one of the constituent societies, the National Association of Maternity and Child Welfare Centres and for the Prevention of Infant Mortality.

The Bureau collects information on all matters concerning maternity and child welfare and this information is available for interested persons. There is a small reference and lending library.

The Council has an exhibition which includes model clothing and diets. Exhibits, models and films are obtainable on loan for propaganda and teaching purposes. Inquiries should be sent to the Secretary.

# National Council of Social Service

*26, Bedford Square, London, W.C.1. Telephone: Museum 8944.*  
*President: SIR P. MALCOLM STEWART, Bart., D.L., O.B.E.*

THE National Council of Social Service, which is under the patronage of H.M. The King, was founded in 1919. During this war, as in that of 1914-18, it has been clearly evident that the country has substantial reserves of voluntary service, but that this service needs some central organisation if the available skill, knowledge and experience of social affairs is to achieve its full effect.

The Council is a tripartite structure, drawing its members from the great national voluntary social service agencies, from the statutory authorities, and from the local social service organisations and, with variations to suit

contemporary conditions and needs, it has maintained throughout its history its essential nature as a co-operative and consultative agency. It now consists of 63 representatives of national voluntary societies, 19 members nominated by Government departments or the National Association of Local Government Authorities and their officers, and 72 representatives of local social service organisations in town and countryside.

During the present war the Council has particularly encouraged the development of consultative groups or standing conferences, representative of the interests in one or another particular field of social effort. These conferences enable the voluntary agencies engaged on similar kinds of social work to meet in common council, and afford a ready means of co-operation between the statutory and voluntary agencies engaged on the same problems. The conferences are autonomous bodies. The Council provides them with secretariat; with common services, such as library and information; and also constitutes a means of integrating the work, policies and programmes of social agencies in all fields. The first of these consultative groups was the Standing Conference of National Juvenile Organisations (now the Standing Conference of National Voluntary Youth Organisations) formed in 1937. Others, formed since the war, are the Women's Group on Public Welfare, representative of the principal women's organisations, and the Churches Group, representative of the religious denominations. In 1944, there was established a close working arrangement with the National Association of Maternity and Child Welfare organisations (a consultative organisation among the social agencies engaged in the field of work) as well as a national Old People's Welfare Committee.

From its earliest days the Council has tried to encourage the growth of local co-operative and consultative agencies, to serve, in their own areas, the same purposes as those aimed at by the Council itself in the country as a whole. The growth of these local councils of social service has been spasmodic, but recent conferences and the issue of a new statement of policy suggest that there will be a considerable move forward after the war. Rural community councils now cover 26 administrative centres, and here again the war has shown a revival of interest and a closer sense of the inter-relation between the social problems of town and country. From 1928 onwards the Council has been closely concerned with the social problems of neighbourhood community life, beginning with the new housing estates of the inter-war years. There has been a remarkable revival in this idea and the Council's community centres' and associations' work is being rapidly increased to meet the demand for advice and guidance.

The Council is represented throughout the country by regional officers who are in direct personal contact with social affairs in their areas, and whose advice and guidance on local matters is always available.

The Citizens' Advice Bureaux service is perhaps the most notable new voluntary service initiated by the Council in the present war. This was created to meet the wartime need of citizens for advice and information. It is based on the work of many experienced voluntary organisations, particularly the case-work agencies, which undertook services of the kind before the war. The Council provides a headquarters staff and a central service of information for the 1,030 Citizens' Advice Bureaux throughout the country.

The Council is financed largely by voluntary subscription, although it receives some assistance from the State in respect of particular services,

such as that of the Citizens' Advice Bureaux. On the other hand, the Council administers considerable funds for many kinds of voluntary social service. The National Council of Social Service Benevolent Fund recovers income tax on charitable donations made under seven-year deeds of covenant and, through this fund, distributes over £390,000 a year to charitable organisations. The Council also advises on the administration of funds from the Carnegie United Kingdom Trust for the building of village halls.

Study and research into social problems is another activity which the Council has developed in wartime and which is likely to develop considerably during the transition period from war to peace. The Council is strengthening its information and publication services. A library and books advice service for active social workers and administrators has already been started at 32, Gordon Square, London, W.C.1. Inquiries should be sent to the Secretary, George E. Haynes, O.B.E.

## National Council for the Unmarried Mother and Her Child

*Carnegie House, 117, Piccadilly, London, W.1. Telephone: Mayfair 1019.*  
*President: The RT. HON. LORD GORELL, C.B.E., M.C.*

THE Council came into existence in 1918 in order to help the illegitimate child and its mother. To this end it has worked for legislative reform, especially in connection with the Bastardy and Affiliation Acts, and has kept a close watch on all legislation that was likely to affect the illegitimate child. Administration has also been carefully watched and the Council has tried to do what it can to encourage local public authorities to make full and wise use of their powers for the care of mothers and children.

The Council promotes the establishment of hostels, homes and other suitable accommodation to meet the varying needs of mothers and babies throughout the country, with the special aim of keeping mother and child together.

There is a Case department which deals with individual enquiries for or on behalf of, mothers of illegitimate children. During its existence it has dealt with many thousands of cases. It is in touch with moral welfare workers and with other organisations all over Great Britain, so that mothers can be helped and advised as speedily and thoroughly as possible. The Council is also in touch with kindred organisations in the Dominions and the U.S.A., and before 1939, it had correspondents in various parts of Europe. When peace returns it hopes to renew and enlarge its contacts, not only with Europe but all over the world.

Lastly it tries to educate public opinion, by speeches, through the press and by any other appropriate means, upon the needs of the illegitimate child, and its claim upon its fellow citizens for all possible help in promoting its well-being and enabling it to attain full and worthy citizenship, despite the handicaps of its birth.

# National Institute for the Blind

224-6-8, Great Portland Street, London, W.1. Telephone: Euston 5251.

*President:* CAPTAIN SIR BEACHCROFT TOWSE, V.C., K.C.V.O., C.B.E.

THE National Institute for the Blind is a voluntary organisation, governed by an Executive Council comprising five groups: Representatives of regional associations for the blind, of local government bodies, of agencies for the blind and national bodies, of organisations of blind persons, together with national members and one life member.

Its object is the provision of all such services for the blind as can most effectively be rendered by national, rather than local or regional effort. It touches the lives of the 76,500 persons forming the blind population of England and Wales, and also to some extent those of the British Empire. Its main activities include:

**Book Production:** Books, periodicals and music are produced in embossed type. The books printed include biography, fiction, poetry, drama, educational text books and maps. Periodicals cover a wide range. The majority of books and periodicals are printed in Braille type, but the institute also includes publications in Moon, a simpler form of embossing, suitable for the elderly and those whose touch is insensitive. A number of books in Braille for the use of pupils in secondary schools and for blind students at the universities are produced by hand.

**Talking Book Department:** In co-operation with St. Dunstan's, the Institute supplies talking-book machines (*i.e.*, gramophones specially adapted for the recording of books) and has a large lending library of records, available free of charge for blind persons possessing machines.

**Apparatus and Appliances:** Braille writing-machines, games of all kinds adapted for blind players; special clocks and watches, and white walking sticks are among the large variety of apparatus and appliances supplied by the institute. Research into new appliances is being carried on continually.

**Residential Nursery Schools:** These schools, five in number and known as the Sunshine Homes for Blind Babies, receive young blind children whose parents are unable to give the specialised training needed to prepare a blind child for school life. One home is reserved for mentally-retarded children.

**School for the Mentally-retarded:** Here blind children of from 5 to 16, who, though not mentally defective yet require individual treatment, receive their education.

**Two Public Schools:** Blind boys and girls likely to benefit from secondary education, are received at the National Institute's two public schools (Worcester and Chorley Wood). Here they may be prepared for entrance to one of the universities.



**Training and Settlement of Blind Masseurs and Masseuses :** Blind men and women are received at the National Institute's School of Physiotherapy, and are prepared for the examinations of the Chartered Society of Physiotherapy. Qualified blind masseurs and masseuses give treatment under medical supervision at the Eichholz Memorial Clinic and the Institute's Evening Clinic.

**Training of Telephonists :** A School of Training has recently been opened to meet the growing demand for blind telephone operators.

**Placement :** Placement of blind workers in factories side by side with seeing workers has developed considerably since the war and is likely to develop still further in post-war conditions. The placement officers are partially-sighted men (able to demonstrate that blind labour is an economic asset) continually researching into new possibilities of employment.

**Home-workers :** The Institute acts as the agent of certain local authorities in parts of London and the southern Home Counties, for the supervision of blind home-workers, purchasing their materials, and marketing their goods.

**Homes and Hostel :** The Institute is responsible for a number of homes for the blind, including three for the early rehabilitation of civilians blinded by enemy action, convalescent and holiday homes, a home for the deaf-blind, a guest-house for blind ladies, and a school-journey centre (this last is temporarily closed owing to war conditions). A hostel has recently been established by the Institute under the Ministry of Labour at Wimbledon for blind war-workers of both sexes.

**Prevention of Blindness :** The Institute has recently embarked on an intensive sight-saving campaign and has originated a minimum national scheme of prevention.

**Imperial and International Co-operation :** The Institute has for years taken an interest in work for the blind in the Dominions, India and the Colonies, and hopes to extend this interest in the future and to renew the contacts with work for the blind in Europe and elsewhere which have been interrupted by the war.

## National Institute of Industrial Psychology

*Aldwych House, London, W.C.2. Telephone: Holborn 2277.*

*President: The RT. HON. THE EARL OF DUDLEY, M.C., D.L.*

THE National Institute of Industrial Psychology is a scientific non-profit-making association founded in 1921, and is governed by a council elected by its members. Its aim may be briefly stated as the improvement of mental and physical health and contentment in occupational life, by removing obstacles which stand in the path of workers of all grades. The practical work of the Institute falls under two headings: its vocational

guidance service by means of which it advises young people on the careers for which their talents and temperament best fit them; and its industrial investigations, in the course of which it advises employers on means of improving conditions for workers. Under this latter heading it deals with the selection and training of workers, physical environment, improvements in methods of work, and problems of management and workers' relationships.

It carries out research in occupational psychology and seeks to spread knowledge of its principles by means of the publication of a quarterly journal; the maintenance of a reference library and an information service; and the provision of lecturers. Inquiries should be sent to the Secretary.

## National Society of Children's Nurseries

*117, Piccadilly, London, W.1. Telephone: Grosvenor 1556.*

*Chairman of Council: MAJOR CYRIL H. NATHAN, F.C.A.*

THE purpose of the Society is the provision of day and residential nurseries as part of the social services; the establishment of a nationally recognised nursery-nurse training in the case of young children; and the promotion of their welfare and that of their mothers.

Early in this war the Society assisted considerably in the problems of evacuating day nurseries which had to become instead residential homes in the country. It also urged planned evacuation of young children under school age to properly selected residential nurseries and, as air-raids increased, did a great deal of work in setting up and running a substantial number of residential nurseries for "bombed-out babies." These were financed to a considerable extent by American funds. It was represented on three of the Boards connected with the management of these nurseries.

Owing to the demand for married women for munition work, the Government decided in May, 1941 to give a 100 per cent. grant for the setting up of day nurseries and started a really determined drive for their establishment, with the result that there were in December 1944, 1,575 "wartime" nurseries under the auspices of the Ministry of Health and the Department of Health for Scotland, with places for 73,317 children.

The number of nurseries of all kinds affiliated to the Society is at present 1,328, of which 1,278 are approved for training students. On application for affiliation, a technical adviser visits the nursery, views the premises and equipment, meets the staff, and sees the nursery in operation. She makes contact with the local authorities concerned, makes any suggestions she thinks necessary, and finally makes a detailed report for the consideration of the Society's Training Committee. While the Society aims at a maximum standard in affiliated nurseries it is not felt possible to insist upon that maximum during the war.

**Constitution:** The Council of the Society is elected from its members and is responsible for all its work. There is an Advisory Board consisting of physicians, paediatricians, Medical Officers of Health, legal and other

experts. Under the Council are the Northern Regional Committee, the Training Committee and the Examiners' Committee. The Society is financed by affiliation fees, examination fees, subscriptions, and voluntary contributions. Generous grants have been received from the British War Relief Society (Inc.) of the U.S.A.

**Training Scheme :** The usual age for training is 16-18 years, but older and younger students are taken in some nurseries. All nurseries used under the scheme are affiliated to the Society and approved as training schools. The period of training, which covers the care of healthy children up to 5 years, is from 18 months to 2 years. Trainees work to a curriculum, the practical training in the nursery being accompanied by a course of lectures which are to an increasing extent given outside the nursery and by outside qualified lecturers.

At the end of the training period students sit for the Society's practical and theoretical examinations, and receive, if successful, the Nursery Nurses' Diploma. At present there are about 4,000 students in training. The Government has officially stated that the wartime nurseries could not have been staffed without the nursery-nurses trained under the Society's scheme. The post-war plans regarding the training of the nursery-nurse have been and are being worked out in a series of reports on varying aspects of the subject.

**Courses for Matrons :** The Society (in conjunction with the Royal College of Nursing and the Association of Sick Children's Hospital Nurses) has conducted a series of short courses for nursery matrons who as State-registered nurses have had little experience of the care of normal healthy children. These were officially recognised by the Ministry of Health, which defrayed the cost.

**Publications and other Educational Activities :** The Society publishes and distributes literature about the running of nurseries and on general propaganda, and a monthly magazine, *The Nursery Journal*. It also carries on correspondence and publishes articles, etc., in the Press. In addition, conferences, and lectures to women's organisations and schools, etc., are used to bring the aims and activities of the Society before the public. Information and advice are given at the Society's offices. At the request of the National Council for Maternity and Child Welfare, a Group Committee is working on reports on a pre-nursery and an advance training course in relation to the training of the nursery-nurse.

**Post-War Plans :** The post-war plans of the Society are set out in the Chairman's *Four Years Plan for Children's Nurseries*, in which it is suggested that a four-year plan prepared now, should be put into operation within at most a year from the end of hostilities for the provision of approved nurseries with accommodation for 300,000 children. Some of these children need full-time nurseries because their mothers go out to work, some because of sickness in the home or for other specific reasons. Many other children under five will require a nursery day once a week for, say, 48 weeks a year, so as to receive regular and frequent observation by skilled staff, and to provide mothers with relief and holiday on one full day a week, in accordance with what is regarded as an urgent social necessity.

**Membership :** This is by election and is open to all having an interest in child care. There is a small annual subscription. Inquiries should be sent to the Honorary Secretary.

# National Society for the Prevention of Cruelty to Children

*Victory House, Leicester Square, London, W.C.2. Telephone: Gerrard 2774.*

*President: HER ROYAL HIGHNESS THE PRINCESS ELIZABETH.*

A SOCIETY for the Prevention of Cruelty to Children was formed in London in 1884. Its founder, Benjamin Waugh, striving against innumerable difficulties, was instrumental in placing on the Statute Book the first Act for the Prevention of Cruelty to Children, with its memorable provision that henceforward it was an offence for parent or guardian wilfully to treat a child in a manner likely to cause it unnecessary suffering or injury to health. The provisions of this Act have been repeated down the years in successive Children Acts.

At first the Society confined its activities to the Metropolis but it was not long before they covered the whole of England, Wales and Ireland. It then became the *National Society for the Prevention of Cruelty to Children* and is now under the patronage of T.M. the King and Queen and of H.M. Queen Mary. Under a Royal Charter assigned to it by Queen Victoria in 1895 the following duties were assigned to the Society: To prevent the public and private wrongs of children and the corruption of their morals; to take action for the enforcement of laws for their protection; to provide and maintain an organisation for the above objects; to do all other such lawful things as are incidental or conducive to the attainment of the above objects.

In a sentence the object of the N.S.P.C.C. is to secure its ideal of "every child a happy child." Justice rather than charity is the key-note. It works by the law which it was itself largely instrumental in securing. Its first consideration, however, is not the law but the *child*. Its aims differ from those of other societies seeking the welfare of unhappy children, in that (whilst others house and provide for destitute children) it attempts primarily to foster a sense of responsibility in those parents who make them destitute. It differs, too, from the work of the police in that it begins earlier. Whilst the object of the police in cases of cruelty is to vindicate the law, the Society strives to prevent rather than to punish the cruelty.

The Society first looks into suspicious facts, makes discoveries, utters warnings and, only if these means fail, prepares a case for the Public Prosecutor. Its aim is always the well-being of the child rather than the desire for convictions, and the average case is adequately dealt with by warning and supervision. Such supervision sometimes extends over weeks and even months and under this system, with remarkable frequency, evil practices are given up when the culprit recognises his duty to the child and to the law.

The Society's officers work in close contact with local authorities and with the various ministries interested in the welfare of children. It is the intention in the post-war period to encourage a more extensive collaboration with these departments. To this end, and as soon as conditions

permit, the Society will increase the number of its inspectors to 300, so as to place every part of England, Wales and Ireland within easy reach of a "Children's Man."

As the result of a recent criminal case the N.S.P.C.C. has asked for the views of its inspectors throughout England and Wales about children who, for one cause or another, have been removed from their parents. It is hoped in this way to gain useful information regarding their experience of children sent to homes of various kinds, after the prosecution of parents by the Society.

The Society courts investigation into its methods; is prepared to give an account of its results; and warmly welcomes the active co-operation of every friend of distressed and suffering children.

## Noise Abatement League

*105, Gower Street, London, W.C.1.*

*President:* The RT. HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.

THE Noise Abatement League is a Society formed for the purpose of reducing, and where possible eliminating, all unnecessary and harmful noises.

Its object is to educate the public as to the harmful effects of noise upon health, and to secure general appreciation of the fact that modern silencing methods, especially when undertaken in the early stages of building operations, can very considerably reduce, and often entirely eliminate, both interior and exterior noise.

Where necessary and advisable the League promotes legislation to deal with specific noise problems.

Research work is carried out by a Technical Committee, which also investigates members' noise problems and suggests remedies.

A quarterly magazine is published, entitled *Quiet*.

## Nuffield Foundation

*73, Great Peter Street, Westminster, London, S.W.1.*

*Telephone: Abbey 2414.*

*Chairman:* SIR WILLIAM GOODENOUGH, Bart., D.L.

THE Nuffield Foundation is the result of Lord Nuffield's greatest benefaction. It was established in 1943 as a trust with a capital valued at £10,000,000. The trustees consist of Lord Nuffield, as ordinary trustee, and seven managing trustees including the Chairman.

The three main objects of the Foundation as stated in the Trust Deed, are: The advancement of health, including the prevention and relief of sickness, particularly by the support of medical teaching and research; the improvement of social well-being, particularly by the furtherance of scientific research; and the care and comfort of the aged. The Trust Deed, however, gives effect to Lord Nuffield's desire that the trustees should have wide additional powers of selection and initiative.

Although the major part of the Foundation's activities is likely to be related to the needs of Great Britain, the policy of the Foundation when fully developed will aim at assisting all parts of the British Commonwealth. If, after the war, a common policy for medical and scientific research should be adopted by the various parts of the Commonwealth, it will be the endeavour of the trustees of the Foundation to give all aid they can towards this end.

Inquiries should be sent to the Secretary, L. Farrer-Brown.

## Nuffield Provincial Hospitals Trust

*16, King Edward Street, Oxford. Telephone: Oxford 2712.*

*Chairman: SIR WILLIAM GOODENOUGH, Bart., D.L.*

THE Trust was founded in 1939 by Lord Nuffield, with a capital of 1,000,000 units of Ordinary Stock of the nominal value of 5s. each in Morris Motors, Ltd. The Body of Governing Trustees includes men and women actively identified with voluntary hospitals, medical organisations, universities and local authorities.

The "Purposes of the Trust" include the co-ordination of hospital and ancillary medical services on a regional basis throughout the provinces, Scotland, Wales and Northern Ireland, and the making of financial provision for the creation, carrying on, or extension of those services which, in the opinion of the Governing Trustees, are necessary for this co-ordination.

The Trustees appointed a Provincial Hospitals Regionalisation Council, a Medical Advisory Council and a Women's Advisory Council to assist them in administering the Trust.

By October 1941 (when the Minister of Health announced the Government's post-war policy for hospitals) the Trust had initiated the formation of four regional hospitals councils, and 11 divisional hospitals councils for the purposes of developing its hospitals co-ordination scheme. These are advisory bodies and consist of representatives of the local authorities and voluntary hospitals, the universities, the medical profession and others primarily concerned with hospital and ancillary medical services. In response to the suggestion of the Ministry and the national organisations of local authorities, the Trust then suspended the formation of further hospitals councils for the time being. The existing councils continue to function and to give the Trust considerable assistance. Through these councils, the Trust provides financial assistance for the development of hospital and ancillary medical services in the respective areas. Other objects towards which substantial grants are being made include a Department of Neurology at the University of Liverpool; the creation of a Chair of Psychiatry in the University of Leeds; a neuro-surgical unit at Manchester University; penicillin research; group schools for the preliminary training of nurses; industrial-nursing training courses and bureaux of health and sickness records.

Recently the Trust has been concerned with surveys of hospitals services throughout the greater part of the country. In this the Trust has acted as the agent of the Ministry of Health. The results obtained will be of great value in the planning of hospital services within the new national health service.

The Trust is devoting much attention to the social and preventive side of medicine. A Chair of Social Medicine has been created at Oxford University and the Trust has founded the Institute of Social Medicine, where the Professor works. The Trust is to devote £10,000 a year for ten years to these two purposes and has also made a grant for the institution of a Chair of Social Medicine in the University of Birmingham.

Another development is the encouragement of the study of child health and the Senate and Court of the University of Durham have accepted an offer from the Trust to provide a grant of £15,000 towards the cost of establishing a Chair of Child Health at King's College, Newcastle-upon-Tyne.

At Lord Nuffield's suggestion, the Trust offered £8,000 a year for ten years to the University of Oxford towards the cost of establishing and maintaining a plastic surgery unit. This has been accepted. The new unit will be a centre of training for plastic surgeons and will work in close touch with the University laboratories, in which parallel investigations of the bio-chemical and other problems connected with the growth and repair of tissue, fundamental to plastic surgery, will be carried on.

## Pioneer Health Centre

*Temporary Wartime Address: 8K, Hyde Park Mansions, Marylebone Road, London, N.W.1. Telephone: Paddington 6358.*

*President: The RT. HON. LORD HORDER, G.C.V.O., M.D., F.R.C.P.*

THE "Peckham Experiment" was the concept of two medical research workers, Dr. G. Scott Williamson and Dr. Innes H. Pearse (now the Directors of the Centre), whose researches into the causation of disease had convinced them that the study of disease was throwing no light on the laws of health. Observing that each person is born with a natural resilience and a capacity for health that is seldom achieved, they believed that health might be cultivated, not through immunity, security or prevention, but by providing an environment in which it could grow and spread. They set themselves, therefore, to devise a means by which they could observe how health behaves. The Pioneer Health Centre is thus primarily a scientific laboratory—the first of its kind for the study of the healthy.

Peckham was chosen as a locality in which neither gross poverty nor extreme wealth are present and in which, therefore, a typical cross-section of the population was provided.

The Experiment falls into two stages. The first, 1926–29, took place in a small house in Peckham. The second, 1935–39 (temporarily suspended by the war) was carried on in a specially designed building. The interim was spent in reviewing the findings of the first three years' work (see *The*

*Case for Action* by Innes H. Pearse and G. Scott Williamson) and in planning for the requirements of the second stage in the experiment.

The facilities of the first Centre were limited to a consulting-room, changing-room and bathroom, an afternoon nursery and a small club-room. Conditions of membership here as in the second Centre were a small weekly subscription, *per family* and a periodic health overhaul. At the end of three years it was demonstrated that families would and did avail themselves of this overhaul as a practical means of maintaining their health. The pathological disorders which precede disease, thus early detected, proved much easier to remove than they do at the stage when the patient usually seeks medical advice. At the same time evidence had been found, of a generally-prevailing low vitality which seemed to be caused by social isolation and lack of stimulus to an opportunity for action; that removal of a disorder had in many cases proved useless because, when the patient was returned to these environmental conditions, the trouble recurred.

As a result of these findings, the new Centre sought to provide an environment in which a family could recover vitality through a much fuller use of its faculties. The new building was planned to serve a dual purpose. It housed the modern laboratory for the study of health, and functioned also as a club for the leisure of 2,000 families.

Within this building (open from 2.0 p.m. to 10.0 p.m. on all week-days) were made available opportunities and equipment of every kind, as well as a source from which knowledge on any subject could be drawn from the social and biological staff—not only at scheduled times nor by selected age or sex groups, but as and when people had use for it. There were within the Club no committees or organisers, nor management-planned activities. Natural groupings formed themselves round self-chosen interests, tracing their own social pattern. Here the observing scientists could watch a free society evolving its own order. Partition walls (of which there were few) were all of glass. Members found themselves learning to swim, taking part in a play, making tea for the babies in the nursery, taking up this or that, not at anyone's suggestion but because the sight of others doing things proved to be a natural incentive to action. Planned visibility but the complete absence of planned activity permitted the scientists to observe and correlate natural social behaviour with laboratory findings.

The agreed family health overhaul took place on joining and afterwards at yearly intervals. It included a laboratory and a complete personal examination, the findings of both of which were simply explained when the doctors (man and woman) and the family subsequently met for the family consultation. Members could thus obtain as complete a picture of themselves and of their potentialities as modern science can provide. No advice was given but merely information on what had been found. When disabilities were revealed, parents almost invariably returned asking for advice about remedying them. Treatments were then arranged through the various medical services, in the patient's time and to suit his pocket—for at this stage there was no urgency or emergency. The family consultation ranged over the whole field of its interests and knowledge of everything affecting its welfare was available. Through this simple routine, at regular intervals, the work elsewhere done by 30 different social and medical services was fully covered at one stroke. *The Peckham Experiment* by Innes H. Pearse and Lucy Crocker gives a detailed account of the whole experiment. An interim



report, *Biologists in Search of Material*, on the second part of the experiment, was also made.

The Experiment will be resumed immediately after the war, when the Pioneer Health Centre will become the first training school for those concerned not with the correction and prevention of disease but with the cultivation of health.

## Queen's Institute of District Nursing

57, Lower Belgrave Street, London, S.W.1. Telephone: Sloane 9948.

President and Chairman: The RT. HON. THE EARL OF ATHLONE,  
K.G., P.C., G.C.B., G.C.M.G., G.C.V.O., D.S.O.

THE Queen's Institute of District Nursing was incorporated by Royal Charter in 1889 with the object of providing skilled nursing for the sick in their own homes. It is both non-sectarian and non-political.

The Council of the Institute is composed of the members directly appointed by its Patron, H.M. Queen Mary, as well as representatives of the affiliated District Nursing Associations, the Q.I.D.N. Secretaries' Association, the Association of Queen's Superintendents, and other bodies concerned with and interested in the Health service of the country.

In England and Wales the work is under the direction of the Central Council, the detailed organisation being delegated to appropriate committees. The Scottish and Irish branches have their separate Councils, whose representatives serve on the Central Council.

The Queen's Institute provides free-of-cost training in district nursing for State-registered nurses. The course, which extends for six months and which is taken in one of the affiliated training homes approved by the Institute, includes theoretical instruction as well as practical training in the district. Candidates successful in the final examination are enrolled as Queen's Nurses and each proceeds to a post with a Nursing Association affiliated to the Institute. Success in this examination entitles nurses to the higher rate of salary in accordance with the Rushcliffe Committee's recommendations.

Many Queen's Nurses also hold the C.M.B. and Health Visitor certificates, and thus widen the sphere of their activities.

In some of the training homes, pupil midwives are trained for the C.M.B. Examination, Part II. The employment of fully qualified district nurse midwives, more particularly in the rural areas, has proved both satisfactory and economical. In 1943, 84,459 cases were attended by midwives working in connection with the Queen's Institute, and the fact that the maternal mortality rate for that year was as low as 1.35 per 1,000 total births, is a proof of the value of the Institute's midwifery work.

In many counties the local authorities delegate to the County Nursing Association the public health work for which they are responsible, *viz.* in addition to midwifery, health visiting, school nursing, notification of certain diseases, public assistance cases. Appropriate grants are made to the Associations for this work.

The cost of the general nursing has, more particularly of late years and in the more industrial areas, been met primarily by means of contributory schemes, and also by voluntary donations.

That the Queen's Institute of District Nursing can be said to be almost alone in the national character of its service, is due entirely to its present system of inspection. The work of each nurse is inspected at regular intervals either by one of the Institute's inspectors, or by the superintendent of a County Nursing Association acting on behalf of the Institute. The reports on these inspections are considered by a Committee of the Central Council in London and appropriate entries made on the nurse's record card. The detailed nature of the inspection reports makes it possible for the Central Office to have knowledge of the standard and type of work undertaken by each Association and also of the suitability of the nurses for the various types of work.

In addition to maintaining the standard of district training and nursing throughout the country, the Queen's Institute acts in an advisory and consultative capacity in the interests of the Associations, negotiates with Government departments and is responsible for national schemes such as that made with the approved societies for payment of nursing given to their members by the Nursing Associations.

At the end of 1943 there were 2,338 Nursing Associations affiliated to the Queen's Institute. The total number of nurses working in connection with the Institute at that time was 7,869 and of these 4,493 were Queen's Nurses.

In view of the increased calls likely to be made on district nurses under the future extension of the national health service, the training of a greater number of nurses in district work is one of the most pressing needs of the present time. The improved conditions under which such nurses now work, and the greatly increased salaries payable to them under the Rushcliffe Committee scale, should do much to encourage recruitment to this most important branch of the nation's health service.

The position of the district nursing service under the future national health scheme is not yet clearly defined, but whether a plan on the lines of the Midwives Act, 1936 be adopted, or whether some more uniform scheme be evolved, two points would appear to be of paramount importance, *viz.* : close co-operation between local authorities and the voluntary Nursing Associations, and the retention of the present system of inspection in order that the national character of the work may be continued. The Queen's Institute is of the opinion that in no other way can the present uniform standard of the district nursing service be maintained.

## Royal Association in Aid of the Deaf and Dumb

413, Oxford Street, London, W.1. Telephone: Mayfair 3562.

President: Vacant.

THE Association, which is under the patronage of H.M. The King, was founded in 1840 with the single object of providing the deaf and dumb with

religious instruction and opportunities of worship. St. Saviour's, Oxford Street (now pulled down) was the first church built for their special use.

In 1873 Queen Victoria gave it her patronage and it became "Royal." From this humble beginning sprang the great organisation which aims at helping the deaf and dumb in every phase and throughout their lives. Its objects are to promote their welfare : By providing churches, where services are conducted by specially trained clergy in the language understood by the deaf and dumb ; by establishing institutes, with clubs for social intercourse (the great need of the deaf), recreation—football, cricket, tennis, Scouts, Guides, holiday camps, etc. ; by arranging for the presence of staff for interpreting in all cases where the deaf come in contact with those who can hear ; and by seeking employment for the deaf and dumb (the staff spends much time in going about with deaf people trying to persuade employers to engage them).

Since the end of the last war, the work of the Association has been extended in many directions. In 1919, it worked solely in London. It now covers London, Middlesex, Surrey, Essex and part of Kent, in which area there are over 6,000 deaf and dumb, and has seven churches and institutes, ten chaplains, three laymen and six lady workers. It has also established a maternity home for deaf and dumb women and girls and has taken over a home for deaf and dumb men, accommodating 50 inmates.

Since the outbreak of war the deaf and dumb, though they cannot by reason of their handicap serve in the active forces, have been nevertheless taking their full share in the industrial field. Many are engaged in factories doing war work and others are filling the gaps in industry caused by the calling up of so many men and women. Employers value the deaf and dumb as workers and it is true to say that practically all the available deaf and dumb men and women are usefully employed. Men who have been for years unemployed, are now working. This not only means relief to the rates but also, which is far more important, the restoration of their self-respect in the knowledge that they can be of service to the community. The obvious conclusion is that with the assistance of a capable placement officer and of employers who will co-operate, the deaf and dumb can hold their own in the industrial world.

The deaf and dumb have stayed at their posts and have not been evacuated. They have shared the risks and dangers of air-raids and numbers of them have lost their homes and some even their lives. Many did fire-watching with hearing colleagues. These developments have made the work of the Association even more necessary than ever. The deaf and dumb cannot take advantage of the social amenities provided for the hearing, nor can they benefit to any extent by attendance at ordinary churches.

Special provision for their spiritual and social welfare is, therefore, essential and only an expert staff can provide such help as is needed.

Accordingly in the area of the Association's work, besides the facilities already referred to, arrangements are made for the passing on of news and instructions which the deaf cannot hear for themselves on the wireless, and the staff is always available to visit, advise, help and interpret for them in all difficulties, at hospitals, courts or interviews with employers.

The deprivation of the deaf and dumb is mainly social and spiritual—loneliness and the difficulty of understanding easily and making themselves understood. They are so often like strangers in their own land, English yet isolated from their fellow-citizens. They need friendly help and practical

sympathy. With such help they can and do become happy and useful citizens.

The deaf and dumb receive no State assistance but are entirely dependant on the efforts of voluntary societies, of which the Association is the largest and one of the oldest. Its help is freely extended to the deaf and dumb irrespective of creed. Its efforts are, however, restricted by lack of funds and subscriptions are welcomed.

## Royal College of Nursing

*Henrietta Place, Cavendish Square, London, W.1.*

*Telephone: Langham 2646.*

*President: Miss M. F. HUGHES.*

IN the field of professional organisation the Royal College of Nursing is to the nurse what the British Medical Association is to the doctor ; just as, in the statutory field, the General Nursing Council has its parallel in the General Medical Council. Founded in 1916, the Royal College of Nursing has to-day a membership of 36,500 general-trained nurses, with an additional membership of 16,000 student nurses, who belong to its junior branch, the Student Nurses' Association, open to nurses who are training for any Part of the State Register. Affiliated to it are the Association of Sick Children's Nurses and the Society of Registered Male Nurses.

The aims of the Royal College of Nursing, which is under the patronage of H.M. Queen Mary, can be summed up as follows : To promote the progress of nursing as a profession in all its branches ; to collate and present to governmental and other representative bodies, the views of State-registered nurses on problems of national importance with which their work is concerned and in which their interests are involved ; to encourage post-certificate education by (a) the arrangement of courses of study to cover all branches of nursing work, (b) the award of scholarships and grants, (c) interchange of nurses in peacetime with other countries ; to bring conditions in the nursing profession into harmony with the outlook of the educated girl of to-day ; to put members into closer touch with one another and their organisation for mutual help and benefit ; and to work out plans of post-war reconstruction for the whole profession.

The Royal College of Nursing has an elected Council of 36 members, with provision for area representation ; a third of the members retire annually. The headquarters of the College consists of a large modern building, equipped for every kind of professional and educational activity, and includes the Library of Nursing, one of the finest nursing libraries in the world. A Scottish Board, with offices in Edinburgh, transacts College affairs in Scotland, while a Committee for Northern Ireland, with its own area organiser, has just been set up in Belfast to deal with matters affecting the profession there. Five other area organisers and an industrial nursing organiser act as links between headquarters and the 120 branches and sub-branches which have been established throughout the country, and give help and advice to individual members. The Royal College also keeps in touch with its members through its weekly journal, the *Nursing Times*.

Public health nurses, sister tutors and private nurses all have separate Sections within the College, to deal, both centrally and locally, with matters relating to their specialities, while ward and departmental sisters form local groups within the branches. Privileges of membership include, a loan fund for members, banking and library concessions, special facilities for insurance against accident and illness and for indemnification of members against professional risk, and also the use of the College's seaside cottage in the Isle of Wight. The Federated Superannuation Scheme for Nurses and Hospital Officers, which the College helped to establish, has been of inestimable value in ensuring adequate pensions for all nurses outside local government service.

The Royal College of Nursing functions through two main departments : (1) The Professional Association Department, which specialises in " protective " work, giving advice and assistance to individual members in their professional life and guarding their interests in public measures affecting the profession. (2) The Education Department, which, under the terms of the College's Royal Charter, promotes advances in nursing education and specialises in research into nursing needs.

**Professional Negotiating Machinery :** Owing to its large membership the Royal College of Nursing represents the majority of nurses on the employees' side of the Government Salaries Committees for nurses, and also on the National Advisory Council for the Recruitment and Distribution of Nurses and Midwives set up by the Ministry of Labour and National Service. It is also negotiating with the Ministry of Health regarding the place of nursing in the Government's plan for a national health service.

**Representation on other National Bodies :** The Royal College of Nursing, far from working in isolation, is closely associated with 37 other organisations of national scope. For example it is represented on the Regionalisation Council of the Nuffield Provincial Hospitals Trust, and works in liaison with the British Hospitals Association and King Edward's Hospital Fund for London on nursing problems which are of joint concern.

**War Activities :** In the international sphere the Royal College is a consultant to UNRRA on nursing matters, and, through the Council of British Societies for Relief Abroad (COBSRA), on which it is also represented, the College undertakes special work in connection with the enrolment of nursing personnel, both British and foreign, for the liberated areas.

For a considerable period the Royal College of Nursing had the duty in Scotland and in the London area, of enrolling and distributing trained and assistant nurses for national services under the Civil Nursing Reserve. It collaborates with the Ministry of Health and the Ministry of Labour and National Service with regard to the rehabilitation of war disabled nurses and, with the approval of the latter Ministry, has trained a large number of industrial nurses to meet the needs of war-workers. Under the Board of Trade's wartime regulations it is the body which distributes uniform concessions to private nurses, industrial nurses and school matrons, and it allocates funds, contributed from all over the world, to nurses who have suffered from enemy action.

**Reconstruction and Research :** In 1941 the Royal College of Nursing set up the Nursing Reconstruction Committee under the chairmanship of Lord Horder. This Committee, which is representative not only of the

various national nursing organisations but of organisations allied to nursing, has already issued three Reports which, advocating as they do, many far-reaching reforms, have aroused international interest. It is noteworthy that nearly all the recommendations in the Committee's first Report (on the Assistant Nurse) have been incorporated in the Nurses Act, 1943. The Royal College submitted detailed evidence to the Beveridge Committee on Social Security, and to the Scottish Committee of inquiry into Post-War Hospital Problems, and drew up a memorandum for presentation to the appropriate minister on the Government's proposals for social insurance as they affect the nurse. In 1944, it set up a special Advisory Board on Nursing Education, under the chairmanship of Sir Cyril Norwood and representative of leading nurse educationists and members of the medical and teaching professions, to advise it in the promotion of nursing education and educational policy. The Royal College is also represented on the Committee set up by the Colonial Office, on the Training of Nurses for Work in the Colonies.

**Education Department :** The aim of the Department is to provide post-certificate lectures and courses of study in every branch of nursing, to improve methods of teaching, and to educate leaders for posts of responsibility, either in schools of nursing or in any public health field in which the services of trained nurses are needed. Through this Department the Royal College of Nursing works in close co-operation with the leading schools of nursing and with universities throughout the country. The Director has the assistance of five tutors and a large staff of lecturers, and every year hundreds of nurse students pass through the department's hands, some for prolonged whole-time courses, some for shorter, part-time and correspondence courses, and some for intensive refresher courses. A number of scholarships are awarded annually. In peacetime the department organises annual study tours at home and abroad, while many foreign nurses have participated in the College courses in this country. During the war, co-operation with nurses of other nationalities has, on the whole, been restricted to measures for relief and rehabilitation.

## Royal College of Physicians

*Pall Mall East, London, S.W.1. Telephone: Whitehall 7701.*

*President:* The LORD MORAN OF MANTON, M.C., M.D.

THE College was founded in 1518. As an Examining Body it holds, in conjunction with the Royal College of Surgeons, examinations for the Licence of the Royal College of Physicians and Membership of the Royal College of Surgeons. This Conjoint Board also conducts examinations for many specialist post-graduate diplomas. The College also conducts an examination for its own Membership. Fellowship of the Royal College of Physicians is by election.

**Post-war Activities :** The Consultant Services Committee is working on the details of the consultant and specialist aspects of a possible national health service. The Committee is composed of five Fellows of the Royal College of Physicians, five Fellows of the Royal College of Surgeons and

three Fellows of the Royal College of Obstetricians and Gynaecologists, with representatives of the teaching and non-teaching hospitals and the specialist associations. There are also 20 representatives of the British Medical Association. Every specialist and consultant engaged in every branch of medicine are thus represented.

In conjunction with the other two Royal Colleges, the Royal College of Physicians is drawing up a list of all the consultants and specialists in this country.

A committee of the College has drawn up a scheme for teaching social and preventive medicine and has issued three reports. The committee is also reporting on the development of the practice of social medicine inside and outside the hospitals. Another committee is considering what changes are desirable after the war in the teaching of the medical students and has issued a report; another is concerned with the organisation of psychological medicine after the war and has issued two interim reports; and yet another is concerned with the under-graduate and post-graduate teaching of paediatrics.

The College is also engaged in the consideration of a comprehensive medical service after the war.

## Royal College of Surgeons of England

*Lincoln's Inn Fields, London, W.C.2. Telephone: Holborn 4699.*

*President: SIR ALFRED WEBB-JOHNSON, Bart., K.C.V.O., C.B.E., D.S.O., T.D.*

THE origin of the Royal College of Surgeons of England is to be found in the history of two corporations which flourished in the City of London 600 years ago and more—the Barbers' Guild and the Fellowship or Guild of Surgeons. After a long period of rivalry the two corporations composed their differences and were granted an Act of Union by Henry VIII in 1540. Disharmony between the Barbers and Surgeons recurred and increased until, in 1745, an Act of Parliament established two separate companies.

In 1800 the Company of Surgeons was reconstituted by Royal Charter into the Royal College of Surgeons of London (the name was changed to its present form in 1843) and left the City for the above address. From that date onwards the College has modified its constitution and increased its functions so as to enable it to keep pace with the times.

The College is now governed by a President, two Vice-Presidents, and 21 other members of the Council, who are elected by the Fellows. The Council also invites six representatives of specialist branches of surgery to sit with them and give advice on matters concerning their own subject. The Council guides the affairs of the College, whatever form they take, towards the fulfilment of its object—the promotion of the science and art of surgery.

The principal examining body is the Court of Examiners, who examine both for the Fellowship (F.R.C.S.) and the Membership (M.R.C.S.). The

Fellows number 2,600 and are to be found in every continent of the world. Since 1900 the Honorary Fellowship has been conferred on a limited number of distinguished persons, mostly surgeons in other countries. The Membership is held by nearly 25,000, and to grant this qualification the College combines with the Royal College of Physicians of London, the two Colleges thus constituting by far the greatest licensing body in the country. They also grant, conjointly, specialist post-graduate diplomas in public health, ophthalmology, oto-rhino-laryngology, psychological medicine, anæsthetics, child health, medical radiology, physical medicine, and tropical medicine. The College is also the chief licensing body in dentistry, having granted the L.D.S. (Licence in Dental Surgery) since 1859.

The Museum was, until the present war, the greatest medical museum in the world, housed in five large halls and several subsidiary rooms. Its nucleus was amassed by John Hunter (1728-93), the founder of scientific surgery, famous for his experimental turn of mind. On his death his collection was bought by Parliament for £15,000 and entrusted to the care of the College with grants totalling £27,000 for housing it. A further grant of £7,500 was made in 1922 in connection with the collection of specimens illustrating the injuries and diseases of the last war. The Hunterian Collection has always been the basis and inspiration of the Museum, and around it the Museum was built up, by the acquisition of other collections and by the preparation of specimens within the College, to a total of some 66,000 specimens. About 40,000 of these and a great part of the exhibition rooms were destroyed by enemy action in 1941, and the restoration of the Museum is one of the principal post-war aims of the College. The Museum is in charge of a Professor of Anatomy and a Professor of Pathology. In 1943 the College received a gift of £100,000 from Sir William H. Collins to endow the Department of Pathology, and a further gift of £100,000 in 1945 from the same donor for the Department of Anatomy.

Experimental surgical research has long been one of the activities of the College and particularly during the last 15 years. The Buckston Browne Research Farm was erected and endowed in 1931 by the late Sir Buckston Browne. In 1938 the Research Laboratories in the College were built and equipped by the Bernhard Baron Trustees, who have endowed the Chair of the Professor in charge of the laboratories.

The Council awards a number of research scholarships endowed by various benefactors.

The College administers a magnificent Library of approximately 110,000 volumes, which is particularly rich in collections of journals on surgical and allied subjects. Most of the collections have been amassed by purchase, but there have been many gifts and bequests from members of the medical profession.

The College does not conduct a medical school, but has great influence on medical education in the framing of its examination regulations and by advice given to hospitals on the subject of the training of surgeons. Direct teaching is given, not only through the Museum and the Library, but also by courses of lectures on anatomy, physiology, and all subjects connected with surgery, many of the lectures taking the form of demonstrations of museum specimens.

The Council administers a number of trusts for lectures, prizes, research studentships, and scholarships for medical students. It appoints representa-



tives to sit on the governing bodies of universities and many medical institutions. Its advice is frequently sought by departments of Government on matters concerning the science and art of surgery.

The College works in close harmony with other medical institutions, particularly the Royal College of Physicians of London, the Royal College of Obstetricians and Gynaecologists, and the British Medical Association. It is in association with the Imperial Cancer Research Fund, for whose foundation it was largely responsible, and whose Director is a Professor of Experimental Pathology in the College. The College has instituted a Research Chair in Ophthalmology in conjunction with the Royal Eye Hospital. It conducts a joint secretariat for a number of associations representative of surgical and medical specialities.

Inquiries should be sent to the Secretary, Kennedy Cassels.

## Royal Institute of Public Health and Hygiene

28, Portland Place, London, W.1. Telephone: Langham 2731.

President: Vacant.

THE Royal Institute of Public Health and Hygiene is a voluntary health organisation which seeks to promote the advancement of public health and hygiene in all its branches, especially personal, domestic, and industrial hygiene, and to aid, encourage, and provide means for the study of public health, preventive medicine and hygiene.

Membership of the Institute is by election, at the discretion of the Council, and includes medical practitioners, dental surgeons, bacteriologists, school teachers, State-registered nurses, registered medical auxiliaries, sanitary workers and others whose duties entail a knowledge of public health and hygiene. Members receive the monthly official organ, *The Journal of the Royal Institute of Public Health and Hygiene*; may use the library, reading-room, and inquiry bureau; and may take part in educational and other functions held by the Institute. These include the Annual Congress, at which papers on important aspects of public health and hygiene are read by recognised specialists and discussed by the delegates; monthly discussions on health subjects which are held for the benefit of members; and popular lectures by medical and scientific authorities, which may be attended also by the general public.

The Harben Lectures are delivered annually under the auspices of the Institute, which is also responsible for selecting recipients of the Harben Gold Medal, awarded triennially for "eminent services rendered to the public health," and of the Smith Award, bestowed likewise upon a medical officer who is "recognised as having done the most noteworthy work in the discharge of his official duties."

The Institute is a Metropolitan Post-Graduate Institution, and a recognised course of instruction for candidates for the Diploma in Public Health is conducted, and has been attended by over 1,500 medical practitioners.

The prescribed course includes lectures, laboratory instruction and visits to places of public health interest.

Examinations for the Certificate and Diploma of the Institute are held twice yearly (on the third Saturday of January and June, in London and at the various provincial centres) in the subjects of general hygiene, school hygiene, and mothercraft and child welfare, and are taken by school teachers and members of the public health and allied professions generally. The Sir Malcolm Morris Prize is awarded to the best candidate in the Diploma in General Hygiene. The Certificate of the Institute is recognised as a qualification for nomination as an Associate, and the Diploma for nomination as a Member of the Institute.

In the chemical, bacteriological and serological laboratories a large number of investigations are carried out annually for local authorities throughout the country and for medical practitioners.

The Institute awards a certificate for purity and quality, or for hygiene merit, in respect of articles and products in common consumption or use submitted by manufacturers, shown by laboratory and practical tests to attain the necessary high standard. "Check analyses" are subsequently made upon samples bought in the open market, to ensure that the original standard at the time of certification is being maintained.

Certificated articles and products are displayed as educational exhibits in the Museum of Hygiene, which forms a permanent health exhibition open free to the public daily at 28, Portland Place, London. The museum is divided into sections devoted to foods; beverages; medical, dental and toilet accessories; domestic appliances and equipment; and clothing. Visitors, whether in parties or as individuals, are welcomed and conducted round the Museum and given detailed explanations. Loan exhibits and the services of a demonstrator may be available upon request by the organisers of health weeks and other public exhibitions. The Institute maintains a well-equipped Cookery Demonstration Hall.

Full details of all or any of the above branches of the activities of the Institute may be obtained from the Secretary.

## Royal London Discharged Prisoners' Aid Society

*Buckingham House, Buckingham Street, Strand, London, W.C.2.  
Telephone: Temple Bar 1049.*

*President: The RT. HON. LORD EBBISHAM, G.B.E., D.L.*

THE Royal London Discharged Prisoners' Aid Society had its origin in the middle of the last century, when the need for assistance for discharged prisoners was first beginning to be recognised.

It is one of the oldest, and by far the largest of the prisoners' aid societies in the country, and is an amalgamation of four former societies which operated within smaller areas. These were the Royal Society for the Assistance of Discharged Prisoners, the Surrey and London Prisoners' Aid Society, the Brixton Discharged Prisoners' Aid Society and the Hert-

fordshire Discharged Prisoners' Aid Society. It is affiliated to the National Association of Discharged Prisoners' Aid Societies. It has for its charge the care of all men committed to prison from the courts of London, Middlesex, Surrey and Hertfordshire and consequently its chief centres of work are in H.M. Prisons, Brixton, Feltham, Wandsworth, Wormwood Scrubs and Pentonville.

The Society operates under the Certificate of the Home Secretary, but it is, nevertheless, a voluntary organisation. Its appointed officers have direct access to all men in the prisons in order that they may give consideration to their various needs. The prison authorities give full assistance in the carrying out of this work and are always ready to advise.

The Society aims at the assistance of deserving prisoners on discharge by monetary grants, clothing, the provision of temporary accommodation, assistance in finding employment, and by assistance to wives and families where this is found to be desirable. Welfare officers of the Society are stationed at the prisons and are in constant touch with prisoners. Prisoners who require any help that lies within the scope of the Society are allowed to see these welfare officers at any time during their sentence, and may appear before the Aid Committee, which sits at each prison, and explain their own needs. The Committee then makes such grant as is possible and desirable, and this is given to the man on the day of his discharge. Where desirable a lady visitor of the Society calls at the homes of prisoners. On receipt of her reports the Committee is able to render assistance to wives and families. After discharge there is often need for further assistance, and a central office advises ex-prisoners and assists them in various ways.

In 1944 discharged prisoners numbered over 7,000. Of these, some 4,600 were assisted. In 1,200 cases one or more articles of clothing were supplied so that a man could leave prison adequately and respectably clad, and thus be in a better position to obtain work. Nearly 4,000 received help in cash, and a little over one-third of the men discharged had employment to go to upon their release.

The importance of this work lies in the fact that the severest part of a man's sentence is often felt after his discharge from prison. When he has left prison he finds that many doors are closed to him and he is often without work or money, and is himself conscious of his failure. Unless he is sympathetically encouraged he may find it difficult to restore himself, and may, in desperation, resort again to crime.

Support is given to the Society by the Prison Commission. The work of the welfare officers is welcomed and encouraged in every possible way, so that the needs of every case may be properly assessed and adequate assistance given. The assistance granted is not upon any set form but is conditioned by the needs and merits of the individual concerned.

The authorities through the Prison Commission make a small monetary grant to the Society for every man discharged from prison, and also contribute a considerable proportion of the salaries of its staff and welfare officers. These grants, however, are very far from meeting the cost of the work. Its main support is derived from the contributions of the general public and it is upon these that the assistance to prisoners chiefly depends. In 1944 some £4,600 was spent upon prisoners, over £4,030 of which came from subscriptions received from various public sources.

In the work of reconstruction after the war the problems of delinquency

must receive careful consideration. In the solution of these problems the Society will play an important part. The Society is anxious for wider and more informed interest in the treatment of delinquency, and particularly in the manner and method of restoration. It welcomes the support of all who recognise the importance of the problem.

## Royal Sanitary Institute

90, Buckingham Palace Road, London, S.W.1. Telephone: Sloane 5134.

President: The RT. HON. THE EARL OF BESSBOROUGH, P.C.,  
G.C.M.G.

THE Institute was founded in 1876. Its object is to promote the advancement of sanitary science in all or any of its branches, and the diffusion of knowledge relating thereto. Such was the success of the Institute in the work which was most urgent at that time—namely, the provision of proper sanitary appliances and the establishment of what may be termed environmental sanitation—that the words sanitary science or sanitation have in common speech become somewhat restricted in their meaning. It is therefore important to realise and remember, that the meaning of the word sanitary is “pertaining to health,” and the scope of the operations of the Institute has always extended over the whole of the subjects covered by such various terms as hygiene, public health, preventive medicine and others. In other words, the object of the Institute is to promote the health of the people.

The main activities of the Institute, apart from courses of lectures, are set out below. They extend over the whole British Empire.

One of the most important means of diffusing knowledge of sanitary science is through meetings, which range from the annual Congress, with an attendance of 1,500 to 2,000 persons, to the sessional meetings in London and other towns, which are of course smaller, and intended to be of more local interest.

The maintenance of a library has been the care of the Institute from the beginning, and it now contains a representative collection of works on all aspects of sanitary science, public health, hygiene and allied subjects.

**The Parkes Museum :** This is organised for the teaching of students rather than for the instruction of the general public, the space available and the income which can be devoted to it necessitating some restriction in its scope.

The proceedings of the Institute are published in its *Journal*, which also includes reviews of the latest books and a record of articles of public health interest in the current periodicals.

The need for examinations for the sanitary officers of local authorities was realised from the foundation of the Institute ; these were started in 1877, and have been developed from time to time.

The Institute has a membership of over 6,000, which includes medical officers of health, engineers to local authorities, architects, veterinary surgeons, sanitary inspectors, health visitors, and members of other professions interested in sanitary science.

Much work is done by the Institute which it is impossible to classify.

# Royal Society of Medicine

*1, Wimpole Street, London, W.1. Telephone: Langham 2204.*

**President:** SURGEON REAR-ADMIRAL GORDON GORDON-TAYLOR, C.B., O.B.E., F.R.C.S.

THE R.S.M. was founded in 1805, under the name of the Medical and Chirurgical Society, by the chief London physicians and surgeons of that time, among whom were such distinguished men as John Abernethy and Edward Jenner. They agreed: "That a Society comprehending the several branches of the medical profession be established in London for the purpose of conversation on professional subjects, for the reception of communications and for the formation of a library." Through a series of changes both of title and address, during which it was granted first a Royal Charter in 1834 and subsequently a Supplemental Charter in 1907, the Society attained its present status and influence. By the Supplemental Charter referred to, it took its present title and was empowered to form Sections and to admit to its Fellowship and to Membership of its Sections, the members of other societies which agreed to dissolve and amalgamate. The Societies thus amalgamated desired to set the general welfare of the profession above their separate interests and so to ensure the success of the scheme. They numbered 17 and were as follows: The Pathological Society of London; the Epidemiological Society; the Odontological Society of Great Britain; the Obstetrical Society of London; the Clinical Society of London; the Dermatological Society of London; the British Gynæcological Society; the Neurological Society; the British Laryngological, Rhinological, and Otolological Association; the Laryngological Society of London; the Society of Anæsthetists; the Dermatological Society of Great Britain and Ireland; the British Balneological and Climatological Society; the Otolological Society of the United Kingdom; the Society for the Study of Disease in Children; the British Electro-Therapeutic Society; and the Therapeutical Society.

The Society has been under the patronage, in turn, of every British sovereign since Queen Victoria.

From time to time it has created new Sections. At present there are 23, as follows: Anæsthetics, Disease in Children, Clinical, Comparative Medicine (including representatives of Veterinary Medicine), Dermatology, Epidemiology and State Medicine, History of Medicine, Laryngology, Medicine, Neurology, Obstetrics and Gynæcology, Odontology, Ophthalmology, Orthopædics, Otolology, Pathology, Physical Medicine, Psychiatry, Radiology, Surgery (sub-section: Proctology), Experimental Medicine and Therapeutics, United Services and Urology. Each section has its own officers and council, elects its own members and is autonomous, subject only to financial and general arrangements made by the Council of the Society.

The Society consists of Fellows, Associates and Members of Sections.

## Fellows and Members

The following are eligible: Medical practitioners registered in the United Kingdom of Great Britain and Northern Ireland; dental practitioners who possess a degree, diploma or licence and are registered in the United Kingdom of Great Britain and Northern Ireland; veterinary practitioners registered

at the Royal College of Veterinary Surgeons ; medical practitioners who prove to the satisfaction of the Council of the Society that, at the time of application, they are duly registered in a country within the British Empire, and who furnish such further particulars as shall satisfy the Council of their eligibility for candidature ; others (not specified above) who shall satisfy the Council as to their qualifications and scientific attainments.

### **Associates**

The Council is empowered from time to time and at its sole discretion to elect medical, dental and veterinary practitioners (British or otherwise) who within five years of their first professional qualification apply for election, to be non-corporate Associates of the Society. Associates are entitled, with certain specified exceptions, to all the ordinary privileges of Fellows but retain them only from year to year, and the Council may at any time and without giving any reason, terminate them either generally or in the case of any one or more Associates.

### **The Library**

The Library, which has been enriched by the addition of the Obstetrical, Odontological and Ophthalmological libraries, the collections of other societies and by private gifts, contains over 150,000 volumes and renders an outstanding information service to the Fellows of the Society all over the world, providing reprints, photostatic reproductions, book-film, and translations into English of abstracts of foreign papers. These are provided to Fellows on request, without fee.

### **Meetings**

The Society meets from time to time as announced, for the reading of papers and to discuss important medical questions of general interest. The *Proceedings* of the Society are published monthly and contain records of papers read at the meetings of the Sections, reports of cases, descriptions of specimens, together with the discussions which follow. The editorial principles of the Society are strict and papers accepted for reading are not necessarily published. The Society holds the copyright of its publications but the honorary editors will readily give permission for publication elsewhere.

Further information is obtainable from the Secretary, Geoffrey R. Edwards, M.A., to whom all inquiries should be addressed.

## **Royal Surgical Aid Society**

Salisbury Square, London, E.C.4. Telephone: Central 4584.

Chairman: The RT. HON. THOMAS WILES, P.C.

**T**HE Royal Surgical Aid Society is under the patronage of H.M. The King, who is an annual contributor to the funds. It was the first organisation in London to supply all types of surgical appliances for the relief or

cure of the crippled and deformed. It was established in 1862 in a small room under the shadow of St. Paul's, and it is on record that on the opening day one patient attended and was supplied with an elastic stocking for varicose veins. Since then the Society has supplied no fewer than 1,847,240 appliances of every description, including 652,568 elastic stockings, 412,311 belts and trusses, and 28,139 artificial legs.

It is well to remember that at the time the Society was established, little, if anything, was done for the masses of poor people who had the misfortune to meet with an accident in the course of their employment, or who were handicapped from birth by malformation, or by the lack of a limb.

In many cases where hospital treatment was available an operation, however successfully performed, only partly remedied the matter by leaving the patient without the aid of some mechanical appliance at a later stage. Except for the favoured few this was out of the question. By co-operation with hospitals and kindred institutions the Society has done much to change all this, and to-day there is no difficulty in providing whatever surgical appliance the surgeon may prescribe.

Patients are not merely assisted to obtain an appliance of their choice. The principle originally adopted is maintained and each appliance supplied is first prescribed by a medical man, thus assuring from the outset, that the right kind of appliance is supplied and avoiding any aggravation of the trouble that might be caused by merely having "something comfortable."

The Society is supported by voluntary contributions, and patients who are able to do so are encouraged to contribute towards the cost of their own appliances. Letters are issued to subscribers at the rate of four for each guinea and these they are at liberty to allocate to patients of their own choice.

The Society has branches at Bournemouth, Brighton, Bristol, Cardiff, Colchester, Croydon, Eastbourne, Hastings, Leicester, Lewes, Oxford, Plymouth, Southampton, Stockton, Sunderland, and Tunbridge Wells, and it is hoped that others may be opened when conditions are favourable. By this means the work of the Society is made more widely known and patients derive considerable benefit in the saving of time and money on travelling, especially as in some cases several journeys may be necessary.

Conditions both in and out of industry have vastly improved during the past 80 years. There was a time when schemes of health and social welfare, with their attendant clinics and allied services, were in the nature of experiments or dreams to be fulfilled, whereas now they are growing realities and have come to be part of our everyday life. The Society has already been of assistance in the work of social welfare in connection with some of the large industries, and it is hoped that this service may be extended. Inquiries from welfare officers and others interested are welcomed.

The Society is fully alive to the fact that post-war conditions may necessitate alteration in methods, but it looks confidently to the future in the belief that there will always be a demand for its work which has already brought relief to so many who would otherwise have been heavily handicapped or sadly dependent. It feels too that its long experience will enable it to make a valuable contribution towards providing for the needs of the crippled and disabled after the war.

# St. Dunstan's

*9-11, Park Crescent, London, W.1. Telephone: Welbeck 7921.*

*President: LADY (ARTHUR) PEARSON, D.B.E.*

ST. DUNSTAN'S was founded in 1915 by the late Sir Arthur Pearson, a well-known newspaper proprietor who had gone blind shortly before the war of 1914-18. He had already overcome his own disability to an amazing degree, and he determined that the young blinded men who were then returning from the war should have every opportunity of rebuilding their lives, and should be taught to look upon their blindness not as an affliction but as a handicap which to a great extent could be overcome. In February, 1915, he began his work with two blinded men. By March 26th there were 16 men to care for, and a move was made to a house called "St. Dunstan's" on the Outer Circle of Regent's Park, London. Three thousand men, blinded in the last war passed through St. Dunstan's. Each man stayed for a period of from a year to two years and in that time he "learned to be blind." He learned how to do many things for himself; to get about alone; to dress and shave himself; to be as independent as was physically possible. The training included Braille reading and writing, and type-writing, so that he could read and write his own letters; handicrafts to teach him the use of his hands; and the learning of a profession or occupation to enable him to earn his own living. The occupations taught at St. Dunstan's include massage, telephone-operating, poultry-farming, shop-keeping, mat-making, basket-making, shorthand and typing, boot-repairing, to mention but a few. Moreover, many men have been able to return to the jobs they were doing, or were training to do, before they were blinded. There have been St. Dunstan's journalists, lawyers, salesmen, parsons, and national and local government representatives.

His training finished, the war-blinded man returned to his own home, there to start a new life with confidence and independence. But he did not leave St. Dunstan's care. To the end of his life, he knows that the organisation will keep in touch with him, caring for him in time of trouble, advising in time of need, helping with the education of his children, and encouraging him in every way to lead a full, normal and happy life.

In 1921, Sir Arthur Pearson died, and was succeeded as Chairman of St. Dunstan's by Sir (then Captain) Ian Fraser, a young officer who had been blinded in 1916 and who had for some years been responsible for the After-Care Department.

So St. Dunstan's work was begun, and from its foundation in 1915 until the present day its purpose has remained the same—the training and lifelong care of soldiers, sailors and airmen blinded on war service. Over 1,700 blinded veterans of the last war are still living.

Furthermore, at the outbreak of the present war it was entrusted by H.M. Government with the treatment of serious eye cases arising as a result of enemy action, and its work has been extended to take in—as well as all blinded soldiers, sailors and airmen—those engaged in services subsidiary to the fighting forces, including members of the women's services, policemen, firemen, members of the Merchant Navy and fishing fleet, and personnel of the Home Defence and Air-Raid Precautions services.



The Training Establishment (now at Church Stretton, Shropshire) takes the young blinded men and women when they leave St. Dunstan's Hospital unit at Stoke Mandeville, Bucks., and provides for them a course of re-education and training which may last from one to two years. It is residential and there is no charge whatsoever for board, lodging, education or training in any of the regular occupations or professions, or special courses. St. Dunstan's also provides all necessary apparatus, books and equipment for re-education, training and subsequent work. Many of the instructors are themselves blinded men of the last war. Most of the trades and professions carried on so successfully by the blinded men of the last war are open to young newly-blinded men, while much thought has been given to possible new fields of employment. As a result of extensive research by St. Dunstan's, many blinded men and some women are now working in aircraft and munition factories in all parts of Great Britain, at ordinary wages, on the same terms as their sighted colleagues.

The women who have come to St. Dunstan's have been from the women's services and the nursing service, and there has also been a number who have been blinded at work in munition factories. All receive the same preliminary training as the men, and in addition a special hostel has been established at the Training Centre where they receive special instruction in household duties, including cooking and laundering. Like the men, they go on to receive training in a craft or profession, unless they prefer to return to their homes to carry on their household duties.

St. Dunstan's has homes or affiliated organisations in South Africa, Australia, New Zealand, Canada and India, while every blinded soldier, sailor or airman from the Dominions, if it is impracticable for him to return to his own country for the time being, can come to St. Dunstan's in England and receive all its benefits. So also can blinded members of the Allied Forces, pending their return to their own countries.

## Scottish Council for Health Education

*3, Castle Street, Edinburgh, 2. Telephone: Edinburgh 20020.*

*Chairman: BAILIE VIOLET ROBERTON, C.B.E., LL.D.*

THE Scottish Council for Health Education, the Scottish counterpart of the Central Council for Health Education for England and Wales, was set up in 1943 to take over the functions of the Scottish Committee of the British Social Hygiene Council, which up to then had been concerned primarily with propaganda directed against venereal disease. The new Council will cover the whole field of health education. It is a voluntary organisation but the majority of its members represent local health authorities.

Its objects are to promote and encourage education in the science and art of healthy living and in the principles of hygiene, and to assist statutory bodies in Scotland in providing services of the nature of publicity or educational propaganda for any purpose relating to health. In furtherance of

these objects the Council may arrange meetings, lectures, demonstrations, exhibitions, conferences, and broadcasts ; provide films and lantern slides ; and publish books, periodicals, pamphlets, etc.

The Council has been approved by the Secretary of State as an organisation for the purposes of Section 29 of the Local Government (Scotland) Act, 1929, which enables local authorities to contribute to approved organisations providing services of the nature of publicity or educational propaganda relating to public health.

## Society of Medical Officers of Health

*Tavistock House South, Tavistock Square, London, W.C.1.*

*Telephone: Euston 3923.*

*President:* PROFESSOR R. M. F. PICKEN, M.B., B.Sc., D.P.H.

THE Society was founded in 1856. Membership is open to medical officers and assistant medical officers connected with the control of municipal health services.

Twelve branches in the provinces and Scotland organise local meetings for the discussion of preventive medicine and health administration, and seven groups deal with special subjects (tuberculosis, fevers, maternity and child welfare, school hygiene, dentistry, etc.).

The Council, meeting in London, is nominated by the branches and groups, and deals with all matters affecting the activities of the public health services.

Inquiries should be sent to the Executive Secretary.

## Soldiers', Sailors' and Airmen's Families Association (SSAFA)

*23, Queen Anne's Gate, Westminster, London, S.W.1. Telephone: Abbey 5934.*

*President of the Council:* HER MAJESTY QUEEN MARY.

SINCE its foundation in 1885 for the specific purpose of "providing for the families of men serving in the Second Egyptian Campaign," SSAFA has developed far beyond its original scope. The Association is a voluntary body with three main purposes : To promote the well-being of the families, assisting them to solve their money and domestic problems ; to help them apply for official allowances and grants ; and to give immediate financial help in cases of hardship not covered by Government provision.

**Home Organisation :** The Association, which was incorporated by Royal Charter in 1926, now maintains a home organisation of 1,400 branches, staffed by 20,000 voluntary workers. Its service is available to the families of all soldiers, sailors, airmen, members of the A.T.S., W.R.N.S. and W.A.A.F. and Allied and Dominion troops, but not for officers of commissioned rank. At home, the address of the nearest SSAFA office can be obtained from any Post Office. Serving men and women can get into touch with the Association through their commanding officers, chaplains or welfare officers.

**Overseas Department :** In 1941, the Army Welfare Department asked SSAFA to open an overseas service to handle enquiries—from men serving overseas—about their people at home, and from families at home who were worried about their men on service abroad. The Overseas Department now has branches in the Middle East, Paiforce, Malta, India, Italy, North Africa, South Africa and with the British Army of Liberation in Western Europe and in Greece.

The SSAFA overseas service, which has now been used by more than 100,000 men since May 1941, will be maintained not only for the duration of the war, but so long as there are British armies of occupation in Europe or men on active service in the Far East. New cases are now being opened at the rate of 1,600 a week, and a special training school has been set up at the London headquarters of the Overseas Department, to train new women workers for the overseas branches, where help and advice are available to the troops on the spot in all matters affecting their families and from which inquiries are sent home for investigation and report by the SSAFA home organisation.

**Children's Homes :** In 1941 the first two SSAFA Emergency Rest Homes were opened to provide accommodation for service families rendered homeless through air raids. This initial venture enabled SSAFA to care for children whose mothers had to enter hospital or were, for short spells, unable to look after them. Fourteen Emergency Children's Homes, with annual accommodation for 6,000 children, allowing an average stay of one month per child, are now open. Last year SSAFA opened a Married Families Club in the West End of London, where serving men and their wives—and, if desired, a child—can spend short leaves together in comfort and at a very reasonable cost.

**Clothing :** SSAFA'S Central Clothing Depot in London and the Northern Supply Depot at Liverpool, are now distributing 100,000 garments a month to service families. Most of the new garments, for which clothing coupons, but not money, have to be surrendered, are given by the people of Canada, the United States, the Dominions and neutral countries.

**Other Activities :** The Association acts in an advisory capacity in supplying to the three Service Ministries confirmation of home circumstances upon which applications have been made for compassionate leave ; transfer nearer home or temporary release ; almonises grants made by other funds which have no local interviewing machinery of their own ; provides hospital-trained nurses for district visiting among the families of men in important garrisons at home and overseas (including a large maternity home at Devonport which is approved by the Ministry of Health as a Midwifery Training School) ; and traces the addressees of letters from prisoners-

of-war which are undeliverable by the normal means owing to insufficient addresses.

**Officers' Branch :** Through the Officers' Branch the SSAFA maintains seventy-nine flats at Wimbledon for the widows and unmarried daughters of deceased officers of the three services, and has a Rent Grant Fund now paying just over £700 a year to assist officers' unmarried daughters.

**Post-War Plans :** SSAFA will continue, as now, to be responsible for the families of all service personnel, whether still serving, demobilised, invalided or deceased. The overseas service will be maintained, with other wartime services, just as long as the need remains. Admission to the Children's Homes is to be extended to children of ex-service and deceased men and women during periods of emergency and hardship.

As a result of offers made by SSAFA to the Ministers of Labour and Pensions to help in the process of rehabilitation and return to civil life (by keeping in touch with families and advising them to encourage service men and women to take full advantage of the Government's rehabilitation and treatment schemes), arrangements have been made for the managers of rehabilitation centres, Ministry of Labour resettlement advice offices, and welfare officers at hospitals, to refer to SSAFA any cases affecting the families.

The Association will play an important part in the re-establishment of family life by helping demobilised men and women to smooth out the inevitable difficulties and misunderstandings which follow long periods of separation ; by making grants towards the removal of furniture to permanent homes ; and by enabling deposits to be paid or existing commitments met on hire purchase agreements for essential furniture. Widows are to receive special consideration and help during the period of readjustment from the service allowance to the pension. Help will also be given in emergencies to the families of pensioners, to wives and mothers visiting sick or wounded men in hospitals far from home, and towards medical and funeral expenses.

## Save The Children Fund

*20, Gordon Square, London, W.C.1. Telephone: Euston 5204.*

*President: The RT. HON. LORD NOEL-BUXTON, P.C.*

THE Fund was founded in 1919 and incorporated under the Companies Act in 1921. It is registered under the War Charities Act, 1940. It is a member of the Council of British Societies for Relief Abroad (COBSRA), the officially recognised British body for the co-ordination of voluntary relief effort, and a founder-member of the Save the Children International Union, Geneva.

The Fund is a voluntary social welfare organisation with an international programme. Its scope is defined by the Declaration of Geneva (Declaration of the Rights of the Child) drafted in 1922 by the founder, Miss Eglantyne Jebb (1876-1928) and adopted by the Assembly of the League of Nations in 1924 as the League's Charter of Child Welfare. This Declaration lays it down that "beyond and above all considerations of race, nationality or

creed . . . the child must be given the means requisite for its normal development, both materially and spiritually."

Broadly speaking, the Fund's work falls into three categories—the relief of distress among children, the promotion of child welfare work of a pioneer character and the education of public opinion in the ideals of the Declaration of Geneva. The major work of the Fund is carried out abroad and has included emergency relief on the grand scale and pioneer work for child welfare in some 40 different lands. In Great Britain nursery schools for the children of the unemployed were being established in the Special Areas of Great Britain up to the outbreak of war and these led on to the Fund's special war effort, the establishment in co-operation with the Ministry of Health in England and Wales and the Department of Health for Scotland, of residential nurseries for evacuated children under five, and of day nurseries and nursery schools for the children of women war workers. Another important wartime development is that of junior clubs for school children. These clubs arose from the work which the Fund undertook in the shelters during the heavy air-raids and are proving of value in providing congenial occupations for the children's leisure which would otherwise, in most cases, be spent on the streets.

Among the more important efforts to guide public opinion may be quoted such international events as the First General Child Welfare Congress, Geneva, 1925; the International Congress on the African Child, Geneva, 1931; inquiries into the effects of parental unemployment on child life, Great Britain, 1931; school meals, school holidays and other social welfare questions in this country; and a survey of child life in the occupied countries of Europe. The Fund has published reports of these inquiries and also issues a monthly periodical, *The World's Children*, dealing with child welfare and protection from the international point of view.

## Women Public Health Officers' Association

5, Victoria Street, London, S.W.1. Telephone: Abbey 5002.

President: The LADY CYNTHIA COLVILLE, J.P.

THE first women to enter the public health service were sanitary inspectors and they founded the Women Sanitary Inspectors' Association in 1896. The work of these pioneer women revealed the need for active steps to reduce the very high infant mortality rate, and certain progressive local authorities and a few voluntary organisations, began to appoint health visitors to call at homes and offer help and advice to mothers in the care of young children. The Maternity and Child Welfare Act, 1918, laid upon local authorities the duty of providing maternity and child-welfare services, including the appointment of health visitors, and thus were laid the foundations of this service which now plays such an important part in our national life.

The Women Sanitary Inspectors' Association later extended its membership to health visitors and became the Women Sanitary Inspectors' and Health Visitors' Association. Later, as the School Medical Service developed, school nurses were included and again the name was changed to its present and more comprehensive title of the Women Public Health Officers' Association. With the establishment under the Midwives Act, 1936, of a municipal midwifery service, these latest recruits to the Public Health Service were added to the membership.

There are now twenty-one local centres, covering the whole of England and Wales. Each elects its own officers and representatives on the Executive Committee and arranges its own meetings. The Executive Committee is the governing body and consists of the officers elected at the Annual General Meeting, centre representatives and honorary secretaries of sub-committees. These latter are appointed by the Executive Committee to carry out certain sections of the work.

The objects of the Association are : To safeguard the interests and improve the status of women officers in the Public Health Service (health visitors, school nurses, tuberculosis visitors, sanitary inspectors, municipal midwives, etc.); and to promote the interchange of knowledge of sanitary and social science.

The work falls mainly into three sections :

**Educational :** In addition to lectures, observation visits, etc., arranged by centres, there are post-certificate refresher courses for health visitors, school nurses and tuberculosis visitors. Before the war an annual Winter School for Health Visitors and School Nurses was held at Bedford College, University of London, and two refresher courses for tuberculosis visitors were also organised. Since the war two Summer Schools have been held at Newnham College, Cambridge. Courses of training for health visitors in mothercraft teaching were also arranged. Four of these took place in 1943—two in London, one in Manchester and one in Cambridge (in conjunction with the Summer School). Further courses have been held in 1944 in Durham, Liverpool, Lincoln, Hereford and London. Educational tours were organised before the war in the United Kingdom and abroad, and among the countries visited were France, Switzerland, Holland, Denmark, Germany, Austria, U.S.A. and Canada. A monthly journal (*The Woman Health Officer*) is published.

**Conditions of Service :** The Association as the recognised trade union for health visitors, school nurses, etc., has done much to improve conditions of service for its members. Since 1927 it has pressed for the establishment of national scales of salary for women public health officers. In 1928 it organised a conference of representatives of local authorities to discuss this matter, and this was followed in 1929 by a deputation to the Minister of Health. Since then the establishment of national scales has been kept in the forefront of its programme. The appointment by the Minister of Health in 1941 of the Nurses' Salaries Committee (under the chairmanship of Lord Rushcliffe) was particularly welcomed. The Association's representatives have taken an active part in the work of the Public Health sub-committee which has recommended national scales of remuneration for health visitors, school nurses and other women public health officers. It was also instrumental in securing the reduction to 60 of the retiring age of female nurses,

midwives and health visitors under the Local Government Superannuation Act 1937, with a compensatory allowance for the loss of five years' service.

**Other Activities :** The Association is the medium for the expression to the appropriate Government departments, local authorities, etc., of members' views on matters concerning their work. An outline of the Association's views on *A Health Service for the Nation* has recently been published. Such problems as evacuation, the supervision of the child minded by day, the need for more day and residential nurseries, the best use of qualified health visitors in wartime, the closer co-operation of midwives and health visitors, the future training of health visitors, the need for a statutory qualification for school nurses, and so forth, have been the subject of representations to the Ministry of Health, the Ministry of Education, etc. The Association also co-operates with other organisations interested in maternity and child welfare and with a number of women's organisations. It is affiliated to the Trades Union Congress.

## Women's League of Health and Beauty

*Hope Cottage, Bullen Street, Thorverton, Exeter.*

*Chairman:* T. J. M. MACLEOD, C.A.

THE Women's League of Health and Beauty was founded in 1930 by Mrs. Bagot-Stack in order to provide evening classes in scientific health exercises for business girls and working women at prices which all could afford and on a nation-wide scale.

A teachers' training college (The Bagot-Stack Health School) was established with two-year courses. Pupils were trained in the Bagot-Stack system of health exercises, dancing, anatomy, physiology, theory of teaching, remedial exercises, public speaking, etc., and on completion of their course they took up careers as teachers in the League's centres. This college has, however, had to close during the war.

In 1937 the League was invited to send a representative to the National Fitness Council. By 1939 it had achieved a membership of 166,000, and had established centres throughout the British Isles and in Canada and Australia. Teams were invited abroad to demonstrate the League's methods, and they attended physical training congresses in Sweden (1939), Finland (1938) and Germany (1938).

During the war the League's activities have been curtailed owing to air-raids, the calling-up of teachers for national service, and other war conditions. To meet these demands, the League's constitution was changed in 1941 to that of a limited liability company, on which basis it has since been conducted. At present a number of centres hold evening exercise classes in towns throughout the country, and classes have also been given by League teachers to members of the women's services and to war workers in factories, and the League has thus continued its work throughout the war. In London,

for example, in spite of bombs and blitzes, League classes have never ceased to be held. Plans are now being laid to re-open the Health School.

Before the war the League performed a useful service to the community in "popularising" fitness, and brought to the notice of many women, who before had been unaware of its importance, the means to achieve it in a practical and enjoyable manner. Friendships were made in the friendly social atmosphere of the classes and much was done to combat the loneliness of some of our large industrial cities.

At the League's Annual Demonstrations (held at Olympia and Wembley Stadium, London) as many as 5,000 members from all over the country and from the Dominions, have been brought together by their common interest in fitness and have not only experienced an improvement in health through joining the League, but have discovered also that their outlook has been widened and their interests increased.

By making women—"the architects of the future"—health conscious the League hopes to travel in a practical way towards its aim of "health leading to peace." It looks forward with certainty to a great increase of its activities and membership after the war and hopes then to take its full and useful share in the reconstruction of Britain.





Eleanor F. Rathbone, M.P.,  
as seen by Sallon.

# Officially Appointed Committees

## Ministry of Health

### MEDICAL ADVISORY COMMITTEE

(Ministry of Health)

**Chairman :** The Minister.

**Vice-Chairman :** Sir W. Wilson Jameson, K.C.B., M.D., F.R.C.P.

**Members :** The President of the Royal College of Physicians ; The President of the Royal College of Surgeons ; The President of the Royal College of Obstetricians and Gynaecologists ; The Chairman of Council of the British Medical Association ; Charles Hill, M.A., M.D., D.P.H. ; James C. Arthur, M.B., B.S. ; Miss Alice Bloomfield, M.D., F.R.C.S., F.R.C.O.G. ; James A. Brown, M.D. ; Sir Ernest Rock Carling, M.B., F.R.C.S. ; John A. Charles, M.D., F.R.C.P., D.P.H. ; Professor Henry Cohen, M.D., F.R.C.P., J.P. ; Sir Allen Daley, M.D., F.R.C.P., D.P.H. ; Edward A. Gregg, L.R.C.P.I., J.P. ; The Lord Horder, G.C.V.O., M.D., F.R.C.P. ; William S. Macdonald, M.C., M.B., J.P. ; Alan A. Moncrieff, M.D., F.R.C.P. ; Professor Ralph M. F. Picken, M.B., D.P.H. ; Professor Harry Platt, M.D., F.R.C.S. ; Alfred T. Rogers, M.B. ; Daniel O. Twining, M.R.C.S., L.R.C.P. ; Oscar Williams, M.B. ; Miss Albertine L. Winner, M.D., M.R.C.P. ; Lieut.-Col. H. L. Eason, C.B., C.M.G., M.D., F.R.C.S.

#### Terms of Reference :

To advise the Minister on the medical aspects of the problems relating to the health of the people.

### COMMITTEE ON MEDICAL SCHOOLS

(Ministry of Health and Department of Health for Scotland)

**Chairman :** Sir William Goodenough, Bart., D.L.

**Vice-Chairman :** Sir John Stopford, M.D., D.Sc., F.R.C.P., F.R.S.

**Members :** Professor T. R. Elliott, C.B.E., D.S.O., M.D., F.R.C.P., F.R.S. ; Dr. A. M. H. Gray, C.B.E., M.D., F.R.C.P., F.R.C.S. ; Professor J. Hendry, M.B.E., M.B., F.R.C.O.G. ; Professor A. V. Hill, O.B.E., Sc.D., F.R.S., M.P. ; Sir W. Wilson Jameson, K.C.B., M.D., F.R.C.P. ; Professor J. R. Learmonth, Ch.M., F.R.C.S.Ed., F.R.S.E. ; Sir Ernest Pooley, K.C.V.O. ; Dr. Janet Vaughan, O.B.E., D.M., F.R.C.P.

**Secretary :** L. Farrer-Brown.

**Observer on behalf of the Government of Northern Ireland :** Professor W. J. Hamilton, D.Sc., M.D., F.R.S.E.

#### Terms of Reference :

Having regard to the statement made by the Minister of Health in the House of Commons on 9th October, 1941, indicating the Government's post-war hospital policy, to inquire into the organisation of Medical Schools, particularly in regard to facilities for clinical teaching and research, and to make recommendations.

The Committee presented its Report in July 1944. It is a full and comprehensive survey, dealing in its three main divisions with :

(a) Undergraduate medical education ; (b) post-graduate medical education and research ; (c) financial considerations.

Bearing in mind the Government's plans for the future health of the nation, the Committee stresses the importance of principles and methods rather than the accumulation of facts.

It considers that medical training should be undertaken at a medical teaching centre, which should be in an integral part of a university and also possess a group of nearby teaching hospitals and suitable clinics. These should function as a unit, with each retaining full authority in its own sphere of responsibility. Of the 30 medical schools in Great Britain, all but four are university schools. No change in the system of government of university medical schools in the English provinces, Wales or Scotland is advocated, other than that the governing bodies of teaching hospitals should be granted representation in the government of the medical schools, if they are not already so represented. The Report recommends that closer links between the University of London and its medical schools should be sought by contributions from both sides. The Committee is of the opinion that the three extra-mural schools in Scotland should cease to train medical students. Similar recommendations concerning the West London Hospital Medical School are given. No support is given to the creation of new medical schools, the Committee feeling that the real need is to secure facilities for the existing schools. It is suggested that, as a long-term policy, the number of entrants to the Universities of Glasgow, Aberdeen and Edinburgh should be decreased. The formation of a special type of school at Oxford to train consultants, teachers and investigators is approved. The Committee recommends that the Charing Cross Hospital should move to Middlesex and that the St. George's Hospital should move to south London, while later the Royal Free Hospital should consider a removal to a site in the northern suburbs, such, for instance, as Highbury.

The Committee is of the opinion that, while participation by the dean of the medical school in academic work is valuable, this will have to be replaced by that of a full-time salaried official.

A chapter devoted to the facilities for clinical instruction suggests that the number and variety of patients in the wards and the out-patients' departments of teaching hospitals, should prove adequate to provide students with complete clinical experience in the various branches of medicine. This factor should be the main consideration determining the number of teaching hospitals required by any one centre. In order to increase the number of doctors, the entry of about 100 students per annum is necessary. These should have access to between 950-1,000 hospital beds and to adequately equipped out-patient departments. The group of teaching hospitals connected with a medical school should consist of at least one parent teaching hospital, which will form the focus of clinical instruction, to which selected patients most suited to the interests of teaching will be directed. Parent teaching hospitals and associate teaching hospitals should be complementary with regard to staffing, the admittance of patients, and clinical instruction facilities.

Higher salaries for full time professors of pre-clinical subjects and more junior staff should be provided. More whole-time professorial appointments in the departments of medicine, surgery, and obstetrics and gynaecology are required, as well as, in some instances, in the departments of child-birth, social medicine and anaesthetics.

Unsuitability should be the only barrier to admission of students wishing to study medicine. The Report favours co-education with a proportion of about 80 per cent. male entrants. Adequate assistance, covering the whole period of training, should be allowed to enable competent pupils to proceed with their studies free of financial embarrassment. Interviews and aptitude tests (and not examination only) should form an integral part of the selection of students. Greater care should be devoted to the health, housing and recreation of students.

The Report recommends that the General Medical Council be granted further powers to carry out detailed reforms in the medical curriculum. The complete course should cover four and a half years, followed by one year in a junior resident post at an approved hospital, before admittance to the medical register.

Post-graduate training and research are considered in detail, together with numerous reforms, such as the further four to five years' training for specialists who, during this period, will hold salaried appointments at the training centres or special hospitals. Detailed recommendations are included on the training of suitable students in the branches of pathology and public health, and of specialists in tropical medicine, in which latter case the students should be appointed to an approved hospital abroad. The Report recommends that the universities should organise refresher courses by approved teachers. Greater use should be made of the exceptional resources of London as a centre for post-graduate education, and a federation of institutions, including the British Post-graduate Medical School, should be formed. The Royal Colleges, with certain exceptions, should have powers to award post-graduate medical diplomas.

All hospital service should possess a uniform system of accounts. The provision for teaching and research should come from public funds, the University Grants Committee having responsibility for distribution. This Committee should appoint an advisory panel of experts with current experience of medical education and teaching hospitals.

Sixteen appendices give information on various relevant topics, including a Report by the Government actuary, and a table showing clinical teaching facilities in 1938 of the various university medical schools.

## COMMITTEE ON DENTISTRY

(Ministry of Health and Department of Health for Scotland)

**Chairman :** The Rt. Hon. Lord Teviot, D.S.O., M.C.

**Members :** L. C. Attkins, L.D.S. ; F. J. Ballard ; E. G. Bearn, C.B., C.B.E. ; Professor R. V. Bradlaw, L.R.C.P., M.R.C.S., L.D.S. ; Professor R. J. Brocklehurst, M.A., D.M. ; T. H. J. Douglas, L.R.C.P. (Edin.), L.R.C.S. (Edin.), F.R.F.P.S.G., L.D.S. ; W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P., L.D.S. ; Major-Gen. J. P. Helliwell, C.B.E., M.R.C.S., L.R.C.P., L.D.S. ; J. F. Henderson, J.P. ; Dr. A. C. W. Hutchinson, D.D.S., M.D.S., L.D.S., F.R.S.E. ; H. T. A. McKeag, B.A., B.D.S. ; H. A. Mahoney, L.D.S. ; Thomas Rankin, O.B.E., L.D.S. ; Alderman W. L. Raynes, M.A. ; Andrew Shearer, O.B.E. ; Councillor John Stewart ; Dame Gwen-doline Trubshaw, D.B.E., J.P. ; R. Weaver, M.D., B.Ch., L.D.S. ; Bryan J. Wood, L.D.S. ; Sir Chad Woodward, F.R.C.S., J.P.

**Secretary :** H. F. Summers.

**Assistant Secretary :** S. G. Game.

**Terms of Reference :**

To consider and report upon : The progressive stages by which, having regard to the number of practising dentists, provision for an adequate and satisfactory dental service should be made available for the population ; the measures to be taken to secure an adequate number of entrants to the dental profession ; existing legislation dealing with the practice of dentistry and the government of the dental profession ; and measures for the encouragement and co-ordination of research into the causation, prevention and treatment of dental disease.

An Interim Report, presented in November 1944, is intended as guidance on general principles affecting the dental aspects of any new health service in preparation by the Health Ministers.

In a general survey of present conditions in the profession, the dental services and the state of dental health of the population, the general conclusions are that the entry rate to the Dentists' Register is not enough to maintain the Register at its present strength ; that public dental services are not closely correlated or without shortcomings ; that the public is ill-educated and apathetic in regard to dental care ; and that the general state of dental health is bad.

As a preface to its recommendations, the Committee states its ideal service as one of regular inspection and treatment of incipient defects, with treatment conveniently and promptly available, with the minimum of formalities and the maximum of personal freedom, and paid for by the community.

The chief recommendation is for the acceptance of the principle of a comprehensive service, available equally to all but not compulsory, and paid for by the community as a whole. This should be an integral part of the national health service.

The general dental practitioner service should, in the view of the Committee, be broadly analogous in principle and structure to that of a general medical practitioner service, with the encouragement of the conception of the "family dentist."

The establishment in suitable areas (after local consultation with the profession) of experimental dental-health centres is recommended, either as separate entities or (preferably) as part of the general health centre. Compulsion should not be applied to either dentists or patients to use these centres. All specialist services should be available for diagnosis and treatment of patients.

The Committee stresses the importance of co-operation and co-ordination by all elements to strengthen the dental service, and of using the expert knowledge of dentists in the planning and administration of the service, both centrally and locally. Although the general service will be available to all, it is anticipated that special groups, such as children and adolescents, and expectant and nursing mothers, will continue to be served by the appropriate authorities. Authorities responsible for the provision of a dental scheme should appoint a chief dental officer to be responsible for the organisation and operation of the service and to have access to appropriate committees.

In order to bring the general public to an appreciation of the need for regular inspection and treatment of teeth, and for oral health in general, the Committee suggests the pursuit, by the proposed central consultative body of dental experts, of a steady policy dealing with the quality of treatment given to the public ; the opportunities for dental health education offered by the health centre ; direct teaching on dental hygiene in schools ; dental

health advice at maternity and child-welfare clinics ; material for publicity (films and posters) from central bodies and education in diet and dental hygiene as part of general health education.

Additional recommendations include, the encouragement of suitable ex-Service personnel to take up the profession of dentistry ; the recall as early as possible of dental teachers from the armed forces ; and steps by the Government to make the best use of equipment disposable from the dental services of the armed forces after the war.

## NURSES SALARIES COMMITTEE

(Ministry of Health)

**Chairman :** The Rt. Hon. Lord Rushcliffe, G.B.E.

### EMPLOYERS PANEL

**Association of Municipal Corporations :** Alderman Sir George Martin, K.B.E., J.P. ; E. C. Parr, J.P. ; J. Lythgoe ; C. Banks, M.D.

**British Hospitals Association** (*in conjunction with the King Edward's Hospital Fund for London, and the Nuffield Trust*) : Sir Bernard Docker, K.B.E. ; Miss M. M. Edwards ; S. Clayton Fryers ; G. G. Panter ; W. Hyde, C.B.E. ; J. P. Wetenhall.

**County Councils Association :** Sir Wynne Cemlyn-Jones ; T. O. Steventon ; W. A. Bullough, M.Sc., M.B., Ch.B., D.P.H.

**London County Council :** J. W. Bowen, C.B.E., J.P. ; A. Reginald Stamp ; Sir Allen Daley, M.D., F.R.C.P.

**Queen's Institute of District Nursing :** Lady Richmond.

**Rural District Councils Association :** E. A. Cross, M.B.E., J.P.

**Urban District Councils Association :** Rev. Luther Bouch.

**Secretary :** A. S. Marre.

### NURSES PANEL

**Association of Hospital Matrons :** Miss H. Dey, O.B.E., R.R.C.

**National Association of Administrators of Local Government Establishments :** R. W. Ramsay, M.B.E.

**National Association of Local Government Officers :** H. Allen ; A. G. Bolton ; C. A. W. Roberts, O.B.E.

**Royal College of Nursing :** Miss I. H. Charley ; Miss I. B. Clunas ; Miss F. G. Goodall, O.B.E. ; Miss G. V. Hillyers, O.B.E. ; Miss M. F. Hughes ; Mrs. E. O. Jackson, R.R.C. ; Miss F. Taylor ; Miss M. Wenden ; Miss M. Wilmshurst, O.B.E.

**Trades Union Congress :** Miss D. M. Elliott, O.B.E., J.P. ; G. Gibson ; Miss H. M. Gray ; A. Moyle ; Miss D. E. Westmacott.

### Terms of Reference :

To draw up, as soon as possible, agreed scales of salaries and emoluments for State-registered nurses employed in England and Wales in hospitals and in the public health services, including the service of district nursing, and for student nurses in hospitals approved as training schools by the General Nursing Council for England and Wales.

The Committee has issued the following :

First Report, February 1943 (Cmd. Paper 6424).

Supplement to the First Report, 1943, on the Application of Scales of Salary for the Guidance of Hospital Authorities (H.M.S.O.).

Second Report, December 1943 (Cmd. Paper 6487).

Nurses S.C. Notes (Further Recommendations and Points of Interpretation) Nos. 1-5. Of these Nos. 3, 4 and 5 are obtainable from H.M.S.O. No. 6 is in preparation.

### **Public Health Nurses Sub-Committee**

**Members :** H. Allen ; Miss M. Blanchard ; A. G. Bolton ; Miss I. H. Charley ; Miss H. M. Gray ; W. A. Bullough, M.Sc., M.B., Ch.B., D.P.H. ; Sir Allen Daley, M.D., F.R.C.P. ; J. Lythgoe ; Alderman C. W. Key, J.P., M.P. ; Sir Wynne Cemlyn-Jones ; Alderman Sir George Martin ; Mrs. A. A. Woodman ; Lady Richmond ; Miss D. E. Westmacott ; Miss M. Wilmshurst, O.B.E. ; C. Banks, M.D.

#### **Terms of Reference :**

To put forward proposals for consideration of the main Committee about scales of salaries and emoluments for health visitors, tuberculosis visitors, school nurses, superintendent health visitors and superintendent school nurses employed whole-time by local authorities (including those employed in a combined capacity).

### **Male Nurses Sub-Committee**

**Members :** Sir Allan Daley, M.D. ; Miss F. G. Goodall, O.B.E. ; C. Banks, M.D. ; Miss M. F. Hughes ; J. W. Bowen, C.B.E., J.P. ; A. Moyle ; Miss M. M. Edwards ; C. A. W. Roberts, O.B.E. ; J. P. Wetenhall ; Miss D. E. Westmacott.

#### **Terms of Reference :**

To prepare proposals for consideration of the main Committee.

### **Mental Nurses Sub-Committee of the Nurses Salaries Committee**

**Chairman :** The Rt. Hon. Lord Rushcliffe, G.B.E.

#### **EMPLOYERS PANEL**

**Nominated by Nurses Salaries Committee :** J. W. Bowen, C.B.E., J.P. ; Sir Allen Daley, M.D., F.R.C.P. ; J. Lythgoe ; Alderman Sir George Martin, K.B.E., J.P. ; T. O. Steventon ; J. P. Wetenhall.

**Nominated by Joint Conciliation Committee :** Alderman P. Crowther, J.P. ; L. T. Feldon ; Councillor W. J. Garnett, D.L., J.P. ; Alderman J. H. Hollins, M.P. ; Councillor T. J. Mullins ; Councillor C. A. Stone, M.B.E.

#### **NURSES PANEL**

**Nominated by Nurses Salaries Committee :** Miss H. Dey, O.B.E., R.R.C. ; Miss D. M. Elliott, O.B.E., J.P. ; Miss F. G. Goodall, O.B.E. ; Miss L. L. Payne ; C. A. W. Roberts, O.B.E. ; Miss F. Taylor.

**Nominated by Joint Conciliation Committee :** R. Barker ; C. Bartlett ; A. Flanagan ; G. Gibson ; J. Oakes ; Miss K. M. Willis.

**Secretary :** A. S. Marre.

#### **Terms of Reference :**

To draw up agreed scales of salaries and enrolments of nurses in mental hospitals in the light of the recommendations made by the Rushcliffe Committee.

The terms were later extended to include nurses employed in wards for patients' suffering from mental disorders or mental deficiency in general, or other hospitals and Public Assistance institutions, and the sub-committee interpreted these terms of reference as authorising it to consider such conditions as hours of work and annual leave.

A Report was presented in August 1944 (Cmd. Paper 6542).  
 Mental Nurses S.C. Notes (Further Recommendations and Points of Interpretation).  
 Nos. 1 and 2 are also available (H.M.S.O.).

### **Joint Superannuation Sub-Committee of the Nurses and Midwives Salaries Committees**

**Chairman :** J. Lythgoe (Nominated by Employers Panel of Nurses S.C.).

#### **MEMBERS :**

**Nominated by Employers Panel of Nurses S.C. :** Duncan Fraser; John Durham; A. G. Simons.

**Nominated by Nurses Panel of Nurses S.C. :** Miss F. G. Goodall, O.B.E.; A. Moyle; J. Simonds; Major Wade, M.B.E.

**Nominated by Employers Panel of Midwives S.C. :** G. G. Panter.

**Nominated by Midwives Panel of Midwives S.C. :** Mrs. F. R. Mitchell, O.B.E.

**Nominated by Employers Panel of Scottish Nurses S.C. :** A. Montcrieff Mitchell, M.A., LL.B.; J. D. Imrie, C.B.E.

**Nominated by Nurses Panel of Scottish Nurses S.C. :** Miss F. N. Udell, M.B.E.; Peter Campbell.

**Secretary :** Miss M. Deslandes.

#### **Terms of Reference :**

To advise as to the best method of securing uniformity of superannuation and interchangeability of pension rights for nurses (including assistant nurses) and midwives; the sub-Committee to send copies of its minutes to both Panels (*i.e.*, of the Main Committees).

A Report was presented in March 1945. (Cmd. Paper 6603.)

### **MIDWIVES SALARIES COMMITTEE**

(Ministry of Health)

**Chairman :** The Rt. Hon. Lord Rushcliffe, G.B.E.

#### **EMPLOYERS PANEL**

**Association of Municipal Corporations :** Sir George Martin, K.B.E., J.P.; R. W. Brosch; J. Lythgoe.

**British Hospitals Association :** G. G. Panter; C. S. Wentworth-Stanley.

**County Councils Association :** W. A. Bullough, M.Sc., M.B., Ch.B., D.P.H.; J. Evans; Miss K. J. Stephenson, C.B.E.

**London County Council :** Sir Allen Daley, M.D., F.R.C.P.

**Queen's Institute of District Nursing :** Lady Richmond; Mrs. D. Kevill-Davies, M.B.E.; Mrs. N. L. Cooke Hurle.

#### **MIDWIVES PANEL**

**Association of Supervisors of Midwives :** Miss M. E. Platt.

**College of Midwives :** Miss K. V. Coni; Miss N. B. Deane; F. Grundy, M.D., M.R.C.S., D.P.H.; Mrs. F. R. Mitchell, O.B.E.; Mrs. L. M. Ross; Arnold Walker, M.A., M.B., F.R.C.S., F.R.C.O.G.

**National Association of Local Government Officers :** C. A. W. Roberts, O.B.E.

**Royal College of Nursing :** Miss L. Beaulah; Miss M. G. Sanday; Miss M. F. Webb.

**Trades Union Congress :** Miss L. W. Mantrip.

**Secretary :** A. S. Marre.



**Terms of Reference :**

To draw up agreed scales of salaries and emoluments of State-certified midwives employed in England and Wales on maternity work in hospitals or maternity homes or in the domiciliary midwifery service, of non-medical supervisors of midwives, and of pupil-midwives.

A Report (Cmd. Paper 6460) was presented in July 1943, and Midwives S.C. Notes (Further Recommendations and Points of Interpretation) No. 1 is also available (H.M.S.O.).

**CIVIL NURSING RESERVE ADVISORY COUNCIL**

(Ministry of Health)

**Chairman :** Miss Florence Horsbrugh, C.B.E., M.P.

**Members :** Miss D. M. Smith, O.B.E. (General Nursing Council); Sir Comyns Berkeley, M.D., F.R.C.P., F.R.C.S., F.C.O.G. (Central Midwives Board); Miss D. S. Coode, O.B.E. (Royal College of Nursing); Miss Mary S. Cochrane, R.R.C. (National Council of Nurses); Miss Helen Dey, O.B.E., R.R.C. (Association of Hospital Matrons); Miss Wilmshurst, O.B.E. (Queen's Institute of District Nursing); \*Lady Louis Mountbatten (Order of St. John); Dame Beryl Oliver, D.B.E. (British Red Cross Society); The Dowager Marchioness of Reading (Women's Voluntary Services); Sir Wynne Cemlyn-Jones (County Councils Association); Alderman W. E. Wilford, J.P. (Association of Municipal Corporations); Sir Allen Daley, M.D., F.R.C.P. (London County Council); James Ferguson, M.B., B.Ch., D.P.H. (Society of Medical Officers of Health); W. H. Harper, O.B.E. (British Hospitals Association); Miss D. E. Westmacott (Trades Union Congress).

\*Lady Dunbar Nasmith deputising.

**Terms of Reference :**

To advise the Minister on questions of policy which he may refer to them, arising in connection with the organisation and work of the Civil Nursing Reserve during the present war.

Communications should be sent to the Secretary.

**STANDING ADVISORY COMMITTEE ON TUBERCULOSIS**

(Ministry of Health)

**Chairman :** R. A. Young, C.B.E., M.D., F.R.C.P.

**Members :** James Watt, M.D., D.P.H.; Norman J. England, M.D., D.P.H.; J. E. H. Roberts, O.B.E., M.B., F.R.C.S.; J. V. Hurford, M.D., M.R.C.P., D.P.H.; J. Ferguson, B.A., M.B., D.P.H.; G. Lissant Cox, C.B.E., M.D.; James Ferguson, B.A., M.B., D.P.H.; A. Tudor Edwards, M.D., F.R.C.S.; Sir Allen Daley, M.D., F.R.C.P.; Norman F. Smith, M.D.; A. Davidson, M.D., D.P.H.; A. Sandison, M.D.; E. L. Middleton, M.D., Ch.B., D.P.H.

**Secretary :** J. H. Harley Williams, M.D., D.P.H.

No Terms of Reference available and no Reports issued.

**CENTRAL ADVISORY WATER COMMITTEE**

(Ministry of Health)

**Chairman :** Field Marshal Lord Milne, G.C.B., G.C.M.G., D.S.O.

**Members :** A. E. Cornwall Walker, C.B.E., M.Inst.C.E.; Sir Albert Atkey, J.P.; Lieut.-Col. E. J. Clarke; H. K. Beale; John Chaston, F.C.I.S., F.S.S.; Sir Wynne Cemlyn-Jones; Sir Robert Doncaster, O.B.E., J.P.; Col. A. Heneage, D.S.O., D.L., J.P., M.P.; Major G. T. L. Baker, O.B.E., T.D., M.A.; R. Beddington, C.B.E.; S. R. Hobday, O.B.E., M.Inst.T.; J. E. James.

**Terms of Reference :**

To advise Government departments on the conservation and allocation of water resources, etc.; and to act as an advisory committee interdepartmentally.

# Board of Admiralty

## ROYAL NAVAL PERSONNEL RESEARCH COMMITTEE

(Board of Admiralty and Medical Research Council)

**Chairman :** Sir Edward Mellanby, F.R.S.

**Terms of Reference :**

To advise the Medical Research Council on such investigations as the Council may be asked to undertake on biological, medical and physiological problems.

## NAVAL MEDICAL CONSULTATIVE BOARD

(Board of Admiralty)

**President :** The Medical Director-General of the Navy.

**Terms of Reference :**

To report on medical matters connected with Naval service referred for consideration.

# Air Ministry

## MEDICAL ADVISORY BOARD

(Air Ministry)

**Chairman :** The Director-General of Royal Air Force Medical Services.

**Members :** Sir Girling Ball, Kt., F.R.C.S. ; Sir Joseph Barcroft, Kt., C.B.E., F.R.S., D.Sc. ; Professor F. C. Bartlett, C.B.E., M.A., F.R.S. ; Air Commodore J. J. Conybeare, M.C., M.D., F.R.C.P. (R.A.F.V.R.) ; Professor Sir W. Wilson Jameson, K.C.B., M.A., M.D., F.R.C.P., D.P.H. ; Professor Sir Edward Mellanby, K.C.B., M.A., M.D., F.R.C.P., F.R.S. ; Sir John Herbert Parsons, Kt., C.B.E., F.R.C.S., D.Sc., LL.D., F.R.S. ; Air Vice-Marshal C. P. Symonds, C.B., M.D., F.R.C.P. (R.A.F.V.R.).

**Secretary :** Wing Commander W. T. Buckle, M.B., Ch.B. (M.A.2).

**Terms of Reference :**

To advise the Director-General of Medical Services on all matters that he lays before them regarding : The health of the Royal Air Force as a whole ; medical problems in connection with aviation and standards of medical fitness for flying duties ; and other questions which require discussion.

No meeting has been held since the outbreak of war, but the D.G.M.S. has consulted individual members as and when required.

## PRINCESS MARY'S ROYAL AIR FORCE NURSING SERVICE ADVISORY BOARD

(Air Ministry)

**President :** H.R.H. The Princess Royal, C.I., G.C.V.O., G.B.E.

**Chairman :** The Director-General of Royal Air Force Medical Services.

**Members :** Miss G. Taylor, R.R.C. (Matron-in-Chief); Miss M. K. Blyde, A.R.R.C. (Sister-Matron, King's College Hospital); Miss D. M. Smith, O.B.E. (Matron, Middlesex Hospital).

**Secretary :** Miss N. G. Rees, R.R.C. (Principal Matron).

**Terms of Reference :**

To advise and make recommendations on the following : The selection of candidates for the P.M.R.A.F.N.S. ; the welfare of the nursing profession as a whole and in particular of the nurses serving in the P.M.R.A.F.N.S. ; and service conditions and procedure as they are likely to affect the entry of candidates into the P.M.R.A.F.N.S.

The Board has no powers with regard to the general administration of the P.M.R.A.F.N.S.

## Ministry of Education

### CENTRAL ADVISORY COUNCIL ON EDUCATION FOR ENGLAND

(Ministry of Education)

**Chairman :** Sir Fred Clarke (Professor of Education, and Director, Institute of Education, London University).

**Members :** Miss M. F. Adams (Headmistress, Croydon High School for Girls); Lady Allen of Hurtwood (Chairman, Nursery Schools Association of Great Britain); Dr. C. F. Brockington (School Medical Officer, Warwickshire County Council); Harold Clay (Transport and General Workers' Union); Henry Clay (Principal, Nuffield College, Oxford); Canon F. A. Cockin (Secretary, Council of Church Training Colleges, and Christian Education Movement); Sir Charles Darwin (Director, National Physical Laboratory); Professor Bonomy Dobree (Professor of English Literature, Leeds University); Miss E. Dodds (Warden, Bishop Creighton House, Fulham); Claude D. Gibb (General Manager and Director of C. A. Parsons & Co., Ltd.); Ronald Gould (Headmaster, Welton School, Somerset); Rev. Dr. A. W. Harrison (Secretary, Methodist Education Committee); Professor Willis Jackson (Professor of Electro-Technics, University of Manchester); Col. The Hon. N. A. S. Lytton-Milbanke (National Catholic Youth Association); P. R. Morris (Director-General of Army Education); Professor R. A. B. Mynors (Professor of Latin, University of Cambridge); W. O. Lester Smith (Director of Education, Manchester); Professor J. A. Scott-Watson (Chief Education and Advisory Officer, Ministry of Agriculture); The Hon. Josiah Wedgwood (Managing Director, Josiah Wedgwood & Sons, Ltd.); J. F. Wolfenden (Headmaster, Shrewsbury School); The Hon. Mrs. Youard (Member of Luxmore Committee on Agricultural Education).

**Terms of Reference :**

To advise the Minister upon such matters connected with educational theory and practice as they think fit, and upon any questions referred to them by him.

### CENTRAL ADVISORY COUNCIL ON EDUCATION FOR WALES

(Ministry of Education)

**Chairman :** Principal D. Emrys Evans (University College of North Wales, Bangor).

**Members :** Sir Leonard Twiston Davies (Chairman, South Wales Council of Social Service); Ifan ab Owen Edwards (Founder, Welsh League of Youth); Eric Evans (Chief Inspector, Central Welsh Board); Miss E. R. Evans (Headmistress, Hirwaun Infants School, Aberdare); Lord Kenyon of Gredington; Will Griffith (Secretary, National Union of Teachers Education Committee); Alderman G. F. Hamer

(Montgomeryshire Education Committee); Councillor Llewellyn Heycock (Glamorgan County Education Committee); Dr. Idris Jones; Saunders Lewis; Alwyn Lloyd; Edward Rees (Director of Education, Denbigh); Miss Frances Rees (Headmistress, Cardiff High School for Girls); Professor G. W. Robinson (University College, Bangor); B. B. Thomas (Coleg Harlech); Dr. Elfed Thomas (Director of Education, Swansea); Dr. Olive Wheeler (University College, Cardiff); A. H. Williams (Headmaster, Ruthin Secondary School).

**Terms of Reference :**

To advise the Minister upon such matters connected with educational theory and practice as they think fit, and upon any questions referred to them by him.

**COMMITTEE ON SUPPLY, RECRUITMENT AND TRAINING OF TEACHERS AND YOUTH LEADERS**

(Ministry of Education)

**Chairman :** Sir Arnold McNair (Vice-Chancellor, University of Liverpool).

**Members :** Sir Fred Clarke (Director, University of London Institute of Education); Dr. A. P. M. Fleming (Director, Metropolitan-Vickers Electrical Co., Ltd.); Mrs. Lionel Hichens (Member, Oxfordshire County Council); Sir Frederick Mander (General Secretary, National Union of Teachers); P. R. Morris (Director-General of Army Education, formerly Director of Education, Kent Education Committee); Miss A. H. Ross (Organising Secretary, London Union of Girls' Clubs); Mrs. J. L. Stocks (Principal, Westfield College, University of London); B. B. Thomas (Sometime Warden, Coleg Harlech, Harlech, Merioneth).

**Secretary :** S. H. Wood (Ministry of Education).

**Assistant Secretary :** Miss E. C. Oakden (H.M. Inspector).

**Clerk :** H. W. Hazlewood.

**Terms of Reference :**

To investigate the present sources of supply and the methods of recruitment and training of teachers and youth leaders and to report what principles should guide the Ministry in these matters in the future.

Part II of the Report, which was presented in April 1944, is concerned with youth leaders and teachers in young people's colleges.

It is estimated that the youth service will require a permanent staff of 5,000 to 6,000 leaders, with an annual recruitment of about 300. Training is regarded as essential, although it may not be possible to make it compulsory immediately.

The Report surveys the requirements of a youth leader, and proposes, for the student without previous training or qualifications, a training course of three years, at least a quarter of this being devoted to practical work. It is assumed that the methods of the theoretical part of the course will be those of the tutorial group or seminar, combined with directed private study. The content of the course is not precisely defined, but it is suggested that it should include treatment of the controversial issues of religion, politics and sex, and should lead the individual to work out his own philosophy of life and to form independent judgments. The practical part of the course should include training by one or more tutors with practical experience; continuous work in institutions or among groups of people; residence in a settlement; individual case-work; and camping and other outdoor activities. The course should have coherence and make a contribution to the youth work of the locality.

It is recommended that representatives of the Ministry of Education, accompanied by other qualified persons, should visit all the emergency

courses recognised under Circular 1598, and make available the results of those visits in so far as they offer guidance about the nature, scope and methods of assessment of the courses which should be provided after the war. It is recommended that courses of at least one year should be provided for those whose previous experience and qualifications make a three-year course unnecessary, and that the minimum age for recognition of leaders should generally be 23.

Salaries of youth leaders should be comparable with those of teachers; the service pensionable; and transfer between teaching and youth service facilitated by linking superannuation arrangements and provision of short courses of training.

The Committee considers that training should be organised by the proposed area training authorities, but should be regarded as experimental during the first five years, and that before the end of that period the Ministry of Education should systematise the qualifications required for recognition and outline the nature of the course which it will recognise and aid. As soon as possible the Ministry should require the appointment of trained leaders.

### **WELSH YOUTH COMMITTEE**

(Ministry of Education : Welsh Department)

**Chairman :** J. Griffiths, M.P.

**Members :** W. Arnold ; Group Capt. G. B. Bailey, D.F.C. ; Alun Oldfield Davies ; Alderman H. T. Edwards ; Ifan ab Owen Edwards ; Sir H. Hiles ; Mrs. G. P. Hopkin Morris ; Trevor Jenkins ; Capt. J. Glynn Jones ; Miss Leta Ogwen Jones ; H. Wyn Jones ; A. J. Lush ; Miss Eirwen Owen ; Edward Rees ; T. J. Rees ; William Rowlands ; Mrs. G. B. Thomas.

**Secretary :** H. E. Melvin (Ministry of Education).

#### **Terms of Reference :**

To take such measures as may be possible to persuade county and county borough authorities to set up effective youth committees without delay, and to give due publicity to and to stimulate interest in the importance of the work to be assigned to these committees ; to consult with representatives of the youth organisations, and to assist these to prepare their schemes for the several areas in Wales so that the useful material will, without delay, be available for consideration by youth committees when they get to work ; to ensure co-operation between the various youth organisations ; and to act generally as liaison and advisers between the Welsh youth organisations and Part II authorities, and also through the intermediary of the Chairman, with the National Committee in London.

A sub-Committee of the above was set up in March 1943 with the following terms of reference : To consider what should be the position of the Youth Service after the war.

It was instructed to assume the extension of the school leaving age to 15 without exception, and the establishment of a system of compulsory part-time post-school education for young people up to the age of 18. The sub-committee presented a Report in February 1945. In it the functions of the Youth Service are described as the provision of facilities and opportunities for leisure activity for all young people until they reach adult maturity. The Committee believes in a National Youth Service based on a conception of partnership between the Ministry of Education, the local education authorities and the voluntary organisations, with a division of responsibility to allow the voluntary organisations greater freedom of action in developing

a spirit of pioneering and idealism, while the local education authorities concentrate on the provision of facilities for those of the 15-20 age-groups no longer in attendance at school.

Recommendations for the development of the Youth Service after the war are based on the guiding principle that every young person should have the right of access to the widest and most comprehensive leisure facilities, with complete freedom of choice and expression. An increase in the rate of grant to local education authorities is proposed. It is suggested that existing machinery should continue, with certain modifications, until complete provision is fully implemented.

It is hoped that dualism in grant-aided effort will be avoided. The Committee considers, that the need of young people for facilities and opportunities for the right use of leisure, can be met by statutory authorities, by the provision of youth community centres; and that at the same time the local education authorities should accelerate the development of schemes on a district basis for the provision of camps, swimming-baths, playing-fields, libraries, festivals, etc. The voluntary organisations could then concentrate on their own specific contributions to youth work, within the framework of the local education authority youth centre. During the transition period, direct assistance to voluntary youth groups would be continued, but the Committee anticipates a gradual decrease in the scale of the direct grant to these bodies, as the scale of indirect aid is increased through greater provision of facilities. The same balance should be maintained between the direct grant-aid to the headquarters of the national voluntary organisations and the provision of indirect aid. These facilities and services would include training courses, national camps, and opportunities for travel. Direct grants should still be available to voluntary agencies for special approved purposes.

It is suggested, that direct grant-aids should be given to new organisations only after careful consideration; that local education authorities should be careful before supporting applications for grants from "closed clubs"; and that all educational youth activities (including Young Farmers) should be under the administrative supervision of the Ministry of Education.

## YOUTH ADVISORY COUNCIL II

(Ministry of Education)

**Chairman :** J. F. Wolfenden, C.B.E., M.A. (Headmaster of Shrewsbury School).

**Members :** Miss M. G. Cookes (Principal, Gopsall Street Women's Evening Institute, Hoxton); Miss E. V. Sparks (Youth Service Organiser, Hertfordshire, Member, Executive Committee of the National Association of Training Corps for Girls); Miss J. E. Wolton (Central Club Y.W.C.A.); George Brown (District Officer, Transport and General Workers Union); Col. C. H. Budd, M.C., T.D., D.L. (Chairman, Cambridgeshire and Isle of Ely County Cadet Committee); E. S. Byng, M.I.E.E. (Vice-Chairman, Standard Telephones and Cables, Ltd.); The Rev. H. G. G. Herklots, M.A. (Youth Department, British Council of Churches); B. G. Lampard-Vachell, J.P. (Chairman, Devon County Education Committee); Lieut.-Col. The Hon. N. A. S. Lytton-Milbanke (National Catholic Youth Association); Dr. A. Maberly, M.A., M.B., B.Ch. (Acting Medical Director, Child Guidance Council); R. F. Thurman (Camp Chief and Field Commissioner, Boy Scouts Association); John A. F. Watson, J.P., F.S.I. (Chairman, Southwark Juvenile Court); J. R. B. Wood, M.A. (Director of Education, Wallasey).

**Assessors :** S. W. Harris, C.B., C.V.O. (Home Office); B. L. Pearson (Ministry of Education); W. Taylor (Ministry of Labour and National Service); Sir Robert Wood, K.B.E., C.B. (Ministry of Education).

**Observer :** C. H. Dand (Scottish Education Department).

**Secretary :** H. E. Melvin (Ministry of Education).

**Terms of Reference :**

To consider and report, having regard to the extended period of education, both full-time and part-time, provided for in the reforms proposed in the White Paper on educational reconstruction, what should be the content and purpose of the Youth Service as a medium for furthering the all-round training of adolescents through leisure-time activities.

A Report was presented in 1943 (H.M.S.O.) and a further Report is awaited.

## **ADVISORY COMMITTEE ON HANDICAPPED CHILDREN**

(Ministry of Education)

**Chairman :** F. Messer, M.P.

**Vice-Chairman :** Professor James M. Mackintosh, Barrister-at-Law (Professor of Public Health, London School of Hygiene and Tropical Medicine).

**Members :** A. A. E. Newth, D.P.H. (Senior School Medical Officer, Nottingham) ; E. W. Woodhead (Director of Education, Kent).

In order to assist the Committee in its consideration of any specific question under review, the Minister will, from time to time, appoint, as additional members, persons possessing special knowledge and experience of the particular category of handicapped children concerned.

**Terms of Reference :**

To advise the Minister on such matters relating to children requiring special educational treatment as he may submit to them or as they may consider require investigation.

# **Ministry of Fuel and Power**

## **SAFETY IN MINES RESEARCH BOARD**

(Ministry of Fuel and Power)

**Chairman :** Sir Malcolm Delevingne, K.C.B., K.C.V.O.

**Members :** C. G. Douglas, C.M.G., M.C., B.Sc., D.M., F.R.S. ; C. V. Drysdale, C.B., O.B.E., D.Sc., M.I.E.E., F.R.S.E. ; F. Edmond ; J. R. Felton, O.B.E. ; Major H. M. Hudspeth, D.S.O., M.C., M.Sc. ; F. Llewellyn Jacob, J.P. ; Professor Owen T. Jones, M.A., D.Sc., F.R.S. ; G. Raw, B.Sc., M.Inst.C.E. ; Professor E. K. Rideal, M.B.E., M.A., D.Sc., Ph.D., F.R.S., F.I.C., M.R.I.

**Acting Secretary :** W. C. Giles.

**Acting Director of the Research Stations :** H. F. Coward, D.Sc., F.I.C.

**Terms of Reference :**

To plan and carry out the work of research into the causes of mining dangers and the means for preventing such dangers.

The work of the Board is financed mainly by grants from the Miners' Welfare Fund.

## Home Office

### **WORKMEN'S COMPENSATION: COMMITTEE ON ALTERNATIVE REMEDIES (Contributory Negligence)**

(Home Office)

**Chairman :** Sir Walter T. Monckton, K.C.V.O., K.C.

**Members :** W. P. Allen ; Sir Robert Reid Bannatyne, C.B. ; F. W. Beney, K.C. ; John S. Boyde, LL.B. ; G. R. A. Buckland ; Sir Marshall Millar Craig, C.B., K.C. ; His Honour Judge David Davies, K.C. ; Professor A. L. Goodhart, K.C. ; George A. Isaacs, M.P. ; The Hon. A. E. A. Napier, C.B. ; W. G. de Gruchy Warren.

**Joint Secretaries :** B. J. M. MacKenna ; J. H. McCarthy.

#### **Terms of Reference :**

(a) To consider, having regard to the observations on the subject of alternative remedies in the Report on Social Insurance and Allied Services, and to any developments which announcements by the Government show to be contemplated in connection with that Report, how far the recovery, or proceedings for the recovery, of damages or compensation in respect of personal injury caused by negligence should affect, or be affected by, the provision made, or proposed to be made, under Workmen's Compensation legislation, or under any social insurance or other statutory schemes for affording financial or other assistance to persons incapacitated by injury or sickness, or their dependants ; (b) to consider, having regard to any relevant observations in the aforesaid Report and in the Report of the Law Revision Committee on Contributory Negligence, whether, in the case of injuries to workmen due to their employment, any alteration is desirable in the law governing the liability of employers and third parties, to pay damages or compensation to workmen and their legal representatives and dependants, independently of the Workmen's Compensation Acts ; and (c) to consider the question raised in paragraph 107 of the Report of the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons in regard to the recovery, in whole or in part, of the cost of reconditioning and vocational training in cases of disablement involving employers or third parties ; and to make recommendations.

An Interim Report was presented to Parliament in January, 1945. This stated that, since organisations representative of employers and workmen have not yet given evidence, the Committee proposes that there should be excluded from the draft Bill (giving effect to the recommendations of the Law Revision Committee in their Report on the Law of Contributory Negligence) any provision for the cases of action by workmen against employers, or by employers against workmen, claiming damages for breach of duty. A provision should be inserted empowering the court to apportion the blame between the workman and the person other than the employer, and to order that person to indemnify the employer (or other person claiming indemnity) according to the degree of his fault.

### **ADVISORY COUNCIL ON THE TREATMENT OF OFFENDERS**

(Home Office)

**Chairman :** The Hon. Mr. Justice Birkett.

**Vice-Chairman :** Sir Alexander Maxwell, K.C.B., K.B.E.

**Members :** The Lady Allen of Hurtwood ; Dame Lilian Barker, D.B.E. ; George Benson, M.P. ; The Rt. Rev. The Bishop of Bristol, M.C., D.D. ; G. Clutton Brock ; Harold Clay ; Geoffrey Crowther ; Mrs. Walter Elliot ; Miss Margery Fry ; The



Hon. Lady Inskip ; W. C. Johnson, O.B.E. ; Mrs. A. Creech Jones ; Professor H. J. Laski ; J. Lees-Jones, M.P. ; Dr. W. S. Macdonald, M.C. ; Leo Page ; Miss L. M. Rendel ; Councillor R. G. Robinson ; H. W. Shawcross, K.C.

**Secretaries :** Miss W. M. Goode (Home Office) ; Francis Graham-Harrison (Home Office).

**Terms of Reference :**

To be a council to assist the Home Secretary with advice and suggestions on questions relating to the treatment of offenders.

## **COMMITTEE OF INQUIRY INTO LONDON COUNTY COUNCIL REMAND HOMES**

(Home Office)

**Chairman :** Godfrey Russell Vick, K.C.

**Co-Member :** Miss Myra Curtis.

**Secretary :** Richard A. Forge (Home Office).

**Terms of Reference :**

To consider and report on the provision of remand homes made by the London County Council and on the administration by the Council of such remand homes.

The Report presented to the Home Secretary in January 1945, may be summarised as follows : In the case of the child of seven which gave rise to the inquiry, the child was properly received into the remand home and properly cared for while there ; the London County Council provision of remand homes is now adequate, but there is evidence of over-crowding in the past, partly due to war conditions ; the remand home for boys at Stamford House is satisfactory ; the new girls' home at Marlesford Lodge needs further adaptation and improvement and an error of judgment was made in moving into it before it was ready for occupation ; the administration of the girls' remand home by the Council's officers has lacked interest and enterprise ; there was a definite failure as regards security against absconding at Marlesford Lodge and another as regards the provision of educational and recreational equipment both there and previously at Shirley ; the question of classifying girls according to their sex experience is one of policy, not administration, since there is no agreement on the matter ; the following classes of children and young persons should be either removed from the remand home or housed in a separate wing or floor : (a) children under eight (for whom a nursery home should be provided when peace returns and who might in the meantime be accommodated in a private dwelling-house), (b) girls suffering from venereal disease (as at present), (c) children and young persons committed to Approved Schools (to be transferred as quickly as possible, and much more quickly than at present), (d) children and young persons under punitive detention (for whom a special remand home is suggested) ; housing of boys and girls in separate homes should begin with the age group 8-12. These children should be kept apart from the older children to some extent but need not be housed in a separate building ; the remaining children and young persons need not be separated into classes according to any definite formula, but there should be facilities for them to be separated as thought desirable by the superintendent assisted by skilled supervisors ; it is most important that the time of the children and young persons should be fully occupied with suitable activities and that the necessary staff and equipment should be provided

for the purpose; the Home Office in consultation with local authorities should review the remuneration, recruitment and training of remand home staffs; there should be machinery for easy and frequent consultation between the parties interested in the London remand homes, *i.e.*, the Home Office, the Council and its officials, the Juvenile Court magistrates, the Probation Officers, and the Superintendents of the homes; and the Home Office should make themselves responsible for setting up and operating this machinery.

## Ministry of Labour and National Service

### NATIONAL ADVISORY COUNCIL UNDER THE DISABLED PERSONS (EMPLOYMENT) ACT, 1944

(Ministry of Labour and National Service)

**Chairman :** The Rt. Hon. The Viscount Ridley, C.B.E.

**Members :**

**Appointed after Consultation with Organisations representing Employers :** Brig.-Gen. A. C. Baylay, C.B.E., D.S.O.; E. De Ath; Lieut.-Col. H. Rivers Fletcher, C.B.E.; W. A. Lee, C.B.E.; Major John Chichester Poole, M.C.

**Appointed after Consultation with Organisations Representing Workers :** W. P. Allen; H. L. Bullock; Arthur Deakin, C.B.E.; Dame Anne Loughlin, D.B.E.; James Watson.

**Other Members including Six Men and Three Women who have seen Active Service in the Present War :** Lieut.-Col. The Hon. J. J. Astor, M.P.; Major Sir J. B. Brunel Cohen; Capt. Geoffrey Crawshaw, J.P., D.L.; Chief Commander Elizabeth L. Dixon (A.T.S.); Chief Petty-Officer L. A. C. Faulkner; Professor Thomas Ferguson, M.D., F.R.C.P.E.; Mrs. Margery Kathleen Gartside (late W.A.A.F.); Councillor Andrew Gilzean; I. J. Hayward, J.P.; R. A. Keys (late Coldstream Guards); Dr. R. E. Lane, M.B., B.S., F.R.C.P.; Squadron Leader W. Simpson, D.F.C. (late R.A.F.); Chief Officer Gladys Octavia Snow, O.B.E. (W.R.N.S.); Major-Gen. R. N. Stewart, O.B.E., M.C.; Dr. A. B. Stokes, D.C.H., D.P.M.; Lieut.-Commander Geoffrey William Style, D.S.C. (R.N.); C. G. A. Ward, D.F.M. (late R.A.F.); R. Watson-Jones, F.R.C.S.; Lieut. The Hon. R. F. Wood (late K.R.R.C.).

**Secretary :** R. E. Gomme, O.B.E. (Ministry of Labour and National Service).

**Terms of Reference :**

To advise and assist the Minister in matters relating to the employment, undertaking of work on their own account, or training, of disabled persons.

### INDUSTRIAL HEALTH ADVISORY COMMITTEE

(Ministry of Labour and National Service)

**Chairman :** The Minister.

**Vice-Chairman :** The Joint Parliamentary Secretary (G. Tomlinson, M.P.).

**Members :** The Permanent Secretary; the Chief Inspector of Factories; the Senior Medical Inspector of Factories; A. J. Amor, M.D., M.Sc.; Brig.-Gen. A. C. Baylay, C.B.E., D.S.O.; Professor Arthur W. Ellis, M.D., F.R.C.P.; Sir J. J. Fox,

C.B., O.B.E., D.Sc., F.I.C.; E. G. Fudge, C.B.E.; M. W. Goldblatt, M.D., Ph.D.; Charles Hill, M.A., M.D., D.P.H.; Sir W. Wilson Jameson, K.C.B., M.D., F.R.C.P., LL.D.; Dame Anne Loughlin; The Rt. Hon. Lord Moran of Manton, M.C., M.D., F.R.C.P.; M. W. Paterson, O.B.E., M.C., M.R.C.S., L.R.C.P.; Professor J. A. Ryle, M.A., M.D., F.R.C.P.; William Scholes, A.R.C.S., J.P.; S. L. Smith, D.Sc., F.C.G.I., M.Inst.C.E., M.I.Mech.E.; J. L. Smyth; Miss F. Clare Sykes.

**Secretary :** D. C. Barnes.

#### **Terms of Reference :**

To advise on technical and scientific problems arising out of the current administration of the Department.

## **Ministry of Pensions**

### **CENTRAL ADVISORY COMMITTEE**

(Ministry of Pensions)

**Chairman :** The Minister.

**Members :** Miss E. H. Kelly, C.B.E., J.P.; Lieut.-Col. F. J. F. Edlmann, D.S.O., J.P.; Col. W. Greene, O.B.E., D.L., J.P.; N. J. Wilding Cole, M.B.E.; Brig.-Gen. E. R. Fitzpatrick, C.B.E., D.S.O., D.L.; W. Scott-Evans, O.B.E.; S. E. Perry; A. G. Webb, M.B.E.; Sir J. Smedley Crooke, J.P., M.P.; Major Sir Cyril Entwistle, K.C., M.C., M.P.; Sir Geoffrey le M. Mander, M.P.; Col. Lord Nathan of Churt; J. J. Tinker, M.P.; Sir Henry Fidles, M.P.; Miss Eleanor Rathbone, M.A., LL.D., M.P.; W. Paling, M.P. (Parliamentary Secretary); Sir A. Cunison, K.B.E., C.B., J.P.; H. Parker, C.B., M.C.; Lieut.-Col. Sir A. Heneage, D.S.O., M.P.; L. J. Leek (Chief Regional Officer).

**Secretary :** C. H. Newble.

#### **Terms of Reference :**

The Committee shall consider and report upon any matter which may be put before them by the Minister for their advice and the Minister shall place at the disposal of the Committee the information required to enable them to consider any such matter.

### **COMMITTEE ON ARTIFICIAL LIMBS**

(Ministry of Pensions)

**Chairman :** Major Sir Brunel Cohen.

**Members :** A. A. Atkinson, M.B., Ch.B.Ed.; Capt. F. W. Bain, M.C.; T. H. Hall, B.Sc.; Professor T. P. McMurray, M.B., F.R.C.S.Ed.; H. Parker, C.B., M.C.; G. Perkins, M.C., M.B., M.Ch., F.R.C.S.; Professor H. J. Seddon, M.D., F.R.C.S.

#### **Terms of Reference :**

To consider the design, development and use of artificial limbs and appliances connected therewith.

The Committee's recommendations, announced in Parliament on 1st February, 1945 and accepted by the Minister, were: The formation at an early date of an experimental department, which in the Committee's view would be most suitably located at Roehampton; this department to be under the direction of a whole-time officer of suitable status possessing both medical and technical qualifications; the appointment of a small standing committee to supervise and develop research and advise on improvements in artificial limbs; this advisory committee, membership of which should not be limited to Ministry of Pensions personnel, to work closely with the proposed experimental department.

The Committee recommends the publication of these recommendations, and considers that it should be one of the functions of the research committee to receive and study suggestions from members of the public.

## WAR SERVICE GRANTS ADVISORY COMMITTEE

(Ministry of Pensions)

**Chairman :** Sir Charles Doughty, K.C.

**Vice-Chairman :** Sir George Mitcheson, J.P., M.P.

**Members :** Capt. R. W. Blacklock, D.S.O., O.B.E., R.N. ; W. Dobbie, M.P. ; F. Gould, O.B.E. ; Air Vice-Marshal F. C. Halahan, C.M.G., C.B.E., D.S.O., M.V.O. ; T. A. E. Layborn, C.B.E. ; Councillor Alexander Mackay, J.P. ; W. H. Mainwaring, M.P. ; County Councillor John Mann, J.P. ; G. A. Morrison, M.A., LL.D., M.P. ; Capt. Frank Nicholl ; Major G. Owen, D.S.O., M.P. ; M. A. Reynard, J.P. ; Col. J. M. B. Scott, O.B.E., T.D., J.P. ; Miss Irene Ward, C.B.E., M.P. ; A. G. Webb, M.B.E.

### Terms of Reference :

To consider applications for monetary assistance from persons who, notwithstanding the pay and allowances issued to them by the Service departments, are unable, by reason of their war service, to meet financial obligations which they were formerly able to meet, and to advise the Minister of Pensions thereon.

## War Office

### ARMY MEDICAL ADVISORY BOARD

(War Office)

**President :** Lieut.-Gen. Sir Alexander Hood, K.C.B., C.B.E., M.D., K.H.P. (Director-General, Army Medical Services).

**Chairman :** (Vacant).

**Members :** Lieut.-Gen. Sir Ernest W. C. Bradfield, K.C.I.E., O.B.E., M.B., M.S. (Lond.), F.R.C.S. (ret. Indian Medical Service) (Medical Adviser, India Office) *ex-officio* ; Major-Gen. C. Max Page, C.B., D.S.O., M.B., F.R.C.S. ; The Hon. Col. Sir Alfred Webb-Johnson, Bt., K.C.V.O., C.B.E., D.S.O., T.D., M.B., F.R.C.S. ; Professor J. R. Learmonth, M.B., Ch.B., F.R.C.S.

**Secretary :** Lieut.-Col. (temp.) D. P. Stevenson, R.A.M.C.

### Terms of Reference :

To advise the Secretary of State for War on any questions of policy in connection with Army Medical Services on which he may desire to consult them.

### ARMY PATHOLOGY ADVISORY COMMITTEE

(War Office)

**Chairman :** Major-Gen. L. T. Poole, D.S.O., M.C., M.B. (late R.A.M.C.), K.H.P. (Director of Pathology, War Office).

**Members :** Professor S. P. Bedson, M.D., B.S., M.Sc., F.R.C.S. ; Professor A. D. Gardner, M.A., M.D., F.R.C.S. ; Lieut.-Col. M. H. Gordon, C.M.G., C.B.E., M.D., F.R.S. (late R.A.M.C.) ; P. N. Panton, M.A., M.B. ; Professor G. S. Wilson, M.D., F.R.C.P. ; the Consulting Physician to the Army ; the Consulting Physician in Resuscitation and Transfusion ; the Director of Medical Research and Statistics.

**Secretary :** Lieut.-Col. H. J. Bensted, O.B.E., M.C., R.A.M.C. (Assistant Director of Pathology, War Office).

**Terms of Reference :**

To advise the Director-General, Army Medical Services, on all matters connected with pathology and blood transfusion.

## Scottish Office

### COMMITTEE ON THE CARE OF CHILDREN

(Scottish Office)

**Chairman :** James L. Clyde, K.C.

**Members :** Councillor Dr. May Baird ; C. A. Cumming Forsyth ; Tom Curr ; John W. Gordon ; Councillor Miss Margaret F. Jobson, M.A. ; Lady Margaret Kerr ; Councillor J. B. Stewart Lamb ; Mrs. Elizabeth H. McKerrow, M.A. ; Mrs. Naomi Mitchison ; Mrs. J. C. Paterson ; Councillor Mrs. Jean Roberts ; Provost James Strachan ; The Very Rev. C. W. G. Taylor, D.D. ; Dr. Nora I. Wattie.

**Secretary :** W. Hewison Brown.

**Terms of Reference :**

To inquire into existing methods of providing for orphans and other children deprived of a normal home life and to consider what further methods should be taken to compensate them for the lack of parental care.

### MEDICAL ADVISORY COMMITTEE

(Department of Health for Scotland)

**Chairman :** Sir John Fraser, Bt., K.C.V.O., M.C.

**Members :** Professor E. P. Cathcart, C.B.E., LL.D., F.R.S. ; Dr. George Matthew Fyfe ; Dr. Catherine Harrower ; Professor James Hendry, M.B.E. ; Dr. David Dale Logan, D.S.O. ; Sir Alexander Macgregor, O.B.E., LL.D. ; Dr. Eneas K. MacKenzie ; Dr. R. Richards ; Dr. A. F. Wilkie Millar ; Sir John B. Orr, D.S.O., M.C., LL.D., F.R.S. ; Professor Adam Patrick, M.D., F.R.C.P. ; Professor Sydney A. Smith, C.B.E., M.D., F.R.C.P. ; R. W. Craig, O.B.E., M.D., M.R.C.P., F.R.S.E. (B.M.A. Observer).

The Chief Medical Officer, Department of Health for Scotland, attends meetings *ex-officio*.

**Terms of Reference :**

To advise the Secretary of State on the medical aspects of problems affecting the health of the people.

### SCIENTIFIC ADVISORY COMMITTEE ON PUBLIC HEALTH ADMINISTRATION AND MEDICAL INVESTIGATION IN SCOTLAND

(Department of Health for Scotland)

**Chairman :** Sir John B. Orr, D.S.O., M.C., M.A., M.D., D.Sc.

**Members :** Sir John Fraser, Bt., K.C.V.O., M.C. (Chairman, Medical Advisory Committee, *ex-officio*) ; Sir Edward Mellanby, M.D., F.R.C.P., F.R.S. (Secretary Medical Research Council, *ex-officio*) ; Professor D. F. Cappell, M.D. ; Brigadier F. A. E. Crew, F.R.S., D.Sc.Ed., M.D., F.R.C.P.Ed. ; Professor E. W. H. Cruickshank, D.Sc., M.D., M.R.C.P., F.R.S.E. ; Professor D. K. Henderson, M.D., F.R.F.P.S., F.R.C.P.Ed., F.R.S.E. ; Professor J. Hendry, M.B.E., M.A., B.Sc., M.B., Ch.B., F.R.C.O.G. ; Sir Alexander Macgregor, O.B.E., M.D., D.P.H. ; Professor T. J. Mackie, O.B.E., M.D., D.P.H. ; Professor J. W. McNee, D.S.O., D.Sc., M.D., F.R.C.P., F.R.S.E. ; Professor Charles McNeil, M.D., M.A., F.R.C.P. ; Professor Noah Morris, D.Sc., M.D., F.R.F.P.S., F.R.C.P., D.P.H.

**Co-opted from Scottish Command :** Col. C. V. Macnamara, R.A.M.C. ; Lieut.-Col. A. Sachs, R.A.M.C.

**Medical Secretary :** Dr. I. N. Sutherland.

**Administrative Secretary :** A. J. Purves.

#### **Terms of Reference :**

To advise the Secretary of State for Scotland on the application of the results of scientific research to public health administration, and to promote medical investigations designed to assist the Secretary of State in the discharge of his responsibilities for the health services in Scotland.

### **SCOTTISH NURSES SALARIES COMMITTEE**

(Department of Health for Scotland)

**Chairman :** Professor T. M. Taylor, C.B.E.

#### **EMPLOYERS PANEL**

**Convention of Royal Burghs :** Lord Provost Sir Robert Nimmo, D.L., J.P.

**Association of County Councils in Scotland :** Brig.-Gen. J. D. Crosbie, C.M.G., D.S.O., D.L. ; G. J. McGregor.

**Association of Councils, of Counties, of Cities in Scotland :** G. F. Caldwell ; J. C. Forman ; A. T. Morrison, C.B.E. ; Thomas Scott.

**Scottish Branch of the British Hospitals Association :** H. J. C. Gibson, M.A., M.D. ; J. C. Knox, C.B.E., M.B., Ch.B., D.P.H. ; D. Robertson, M.A., LL.B. ; R. Morrison Smith, C.A. ; (one vacancy).

**Association of Royal Mental Hospitals in Scotland :** W. G. C. Hanna, C.A.

**Queen's Institute of District Nursing :** Harriet, Lady Findlay, D.B.E., J.P.

**Secretary :** W. T. Mercer.

#### **NURSES PANEL**

**National Association of Local Government Officers :** John L. Robson.

**Royal College of Nursing :** Miss M. C. Cameron ; Miss I. Hamilton ; Miss M. Husband, R.R.C. ; Miss J. Mackie ; Miss A. McFadden ; Miss M. Thomson ; Mrs. K. Keir Watson.

**Scottish Trades Union Congress :** J. M. Airrie ; Peter Campbell ; J. Campbell ; Miss A. L. Richmond.

**Scottish Matrons' Association :** Miss E. D. Smail, O.B.E., A.R.R.C.

**Royal British Nurses' Association :** Miss E. Brodie, M.B.E.

#### **Terms of Reference :**

To draw up agreed scales of salaries and emoluments for State-registered nurses employed in Scotland in hospitals, including mental hospitals, and in the public health services, including the service of district nursing, and for student nurses in hospitals approved as training schools by the General Nursing Council for Scotland.

A second Report was issued in April 1943 (Cmd. Paper 6439).

### **Health Visitors Sub-Committee**

#### **EMPLOYERS PANEL**

**Convention of Royal Burghs :** Lord Provost Sir Robert Nimmo, D.L., J.P.

**Association of County Councils in Scotland :** Brig.-Gen. J. D. Crosbie, C.M.G., D.S.O., D.L.

**Association of Councils, of Counties, of Cities in Scotland :** J. C. Forman ; G. F. Caldwell.

**Queen's Institute of District Nursing :** Harriet, Lady Findlay, D.B.E., J.P.

#### **NURSES PANEL**

**National Association of Local Government Officers :** John L. Robson.

**Royal College of Nursing :** Mrs. K. Keir Watson ; (one vacancy).

**Scottish National Health Visitors' Association :** Miss C. Keachie ; Miss M. Balfour.

**Terms of Reference :**

To draw up agreed scales of salaries and emoluments for health visitors, tuberculosis nurses, and school nurses employed in Scotland (including those employed in a combined capacity) and superintendents of health visitors.

**Midwives Sub-Committee****EMPLOYERS PANEL**

**Convention of Royal Burghs :** Lord Provost Sir Robert Nimmo, D.L., J.P.  
**Association of County Councils in Scotland :** Brig.-Gen. J. D. Crosbie, C.M.G., D.S.O., D.L.

**Association of Councils, of Counties, of Cities in Scotland :** J. C. Forman.

**Queen's Institute of District Nursing :** Harriet, Lady Findlay, D.B.E., J.P.

**Scottish Branch of the British Hospitals Association :** H. J. C. Gibson, M.A., M.D.

**NURSES PANEL**

**Royal College of Nursing :** Miss I. Hamilton ; (one vacancy).  
**Scottish Trades Union Congress :** Peter Campbell.

**Scottish Midwives' Association :** Miss J. P. Ferlie, M.B.E. ; Mrs. Quintin Smith.

**Terms of Reference :**

To draw up agreed scales of salaries and emoluments for State-certified midwives employed in Scotland on maternity work in hospitals, maternity homes, or in the domiciliary midwifery service, and for non-medical supervisors of midwives, and for pupil-midwives.

**Mental Nurses Sub-Committee****MEMBERS :**

**Scottish Mental Hospitals Association :** A. T. Morrison, C.B.E. ; Lord Provost Sir Robert Nimmo, D.L., J.P. ; W. G. C. Hanna, C.A. ; J. Dunlop ; G. F. Caldwell ; Major J. B. L. Monteith ; G. Ross ; Provost H. Mackenzie ; J. Risk ; J. C. Forman ; E. E. Webster.

**Mental Hospital and Institutional Workers' Union :** J. Butler ; G. Gibson ; J. T. Waite ; M. McBride ; T. Prentice ; J. Russell ; Miss A. M. Howie.

**Nurses Panel of the Nurses' Salaries Committee :** Peter Campbell ; Miss E. Brodie, M.B.E. ; Miss J. Mackie ; Miss E. D. Smaill, O.B.E., A.R.R.C. ; Miss M. Thomson.

**Terms of Reference :**

To review, as a matter of urgency, the present rates of pay and conditions of service of nurses in mental hospitals and institutions in Scotland, and recommend adjustments, with a view to the making of an order under Defence Regulation 32 AB requiring nurses to continue in employment in such hospitals and institutions.

**HOSPITALS ADMINISTRATION ADVISORY COMMITTEE**

(Department of Health for Scotland)

**Chairman :** Sir John Fraser, Bt., K.C.V.O., M.C., F.R.C.S.

**Members :** Professor Illingworth, M.D., F.R.C.S. ; Dr. J. C. Knox, C.B.E. (Royal Infirmary, Aberdeen) ; Professor Learmonth, F.R.C.S. ; Sir Alexander MacGregor, O.B.E., M.D. ; Professor Noah Morris, D.Sc., M.R.C.P. ; The Hon. Mrs. Stirling of Keir.

**Secretary :** J. D. R. Scott.

**Terms of Reference :**

To advise on the administration of hospitals directly under the Department's control included in the Emergency Hospital Scheme.

**SCOTTISH CIVIL NURSING RESERVE  
ADVISORY COUNCIL**

(Department of Health for Scotland)

**Chairman :** Sir John Jeffrey, K.C.B., C.B.E.**Members :** W. G. Clark, M.B., Ch.B., D.P.H. ; Brig.-Gen. Crosbie, C.M.G., D.S.O., D.L. ; Miss Isabella Cromarty Dewar ; Miss M. Husband ; Miss F. E. Kaye ; A. S. M. Macgregor, M.D., D.P.H. ; Col. D. J. Mackintosh, C.B., M.V.O., LL.D., M.B. ; R. Barclay Ness, M.A., M.B., C.M., F.R.F.P.S. ; Miss R. Pecker ; The Rt. Hon. The Countess of Rosebery ; ex-Provost J. R. Rutherford ; Miss Christine Sinclair ; Miss F. N. Udell, M.B.E. ; Miss C. Mabel Warren, M.B.E.**Terms of Reference :**

To advise the Secretary of State for Scotland on questions of policy arising in relation to the organisation and work of the Civil Nursing Reserve during the present war.

**GLENEAGLES FITNESS CENTRE:  
CONSULTATIVE COMMITTEE**

(Department of Health for Scotland)

**Chairman :** (Vacant).**Members :** Robert Baird ; James Barbour, O.B.E. ; Alex. Cameron ; C. Augustus Carlow ; John Colthart ; George Fingland ; Abe Moffat ; James C. Murray ; William Park, J.P. ; W. G. Patterson ; James Potter ; P. M. Ritchie.**Joint Secretary :** R. J. Prince, O.B.E.**Terms of Reference :**

To assist in ensuring that the benefits of the Fitness Centre at Gleneagles Hospital are recognised throughout the mining industry in Scotland and that the fullest advantage is taken of them ; to assist in the re-employment of patients treated at the centre and to advise on non-medical matters affecting the welfare of patients treated at the centre.

**ADVISORY COUNCIL ON EDUCATION IN SCOTLAND**

(Scottish Education Department)

**Chairman :** Principal Sir William Hamilton Fyfe, LL.D., F.R.S.C.**Vice-Chairman :** Lord Provost Sir Garnet Wilson.**Members :** Miss Agnes M. Allison ; William Barry ; Professor E. P. Cathcart, C.B.E., LL.D., F.R.S., F.R.S.E. ; J. B. Clark, C.B.E., LL.D. ; Thomas Fraser, M.P. ; Ernest Greenhill ; Major E. G. R. Lloyd, D.S.O., M.P. ; William McClelland, F.R.S.E. ; Mrs. Bridget M. McEwen ; R. C. T. Mair, C.B.E., M.C. ; Adam M. Millar, O.B.E. ; Miss Agnes B. Muir ; Ronald M. Munro ; J. E. S. Nisbet ; W. D. Ritchie ; James J. Robertson, F.R.S.E. ; J. Rothnie ; J. Cameron Smail, O.B.E., LL.D., F.R.S.E. ; W. Crampton Smith, O.B.E. ; J. Henderson Stewart, M.P. ; Miss E. J. Taylor ; James Young.**Secretary :** T. Grainger Stewart.**Assistant Secretary :** A. Davidson.**Terms of Reference :**

To advise the Secretary of State on educational matters in Scotland.

**SCOTTISH YOUTH ADVISORY COMMITTEE**

(Scottish Education Department)

**Chairman :** The Hon. Lord Keith.**Vice-Chairman :** William Quin, J.P.



**Members :** Harry Bell, O.B.E., M.A., Ed.B. ; Michael G. Black, O.B.E. ; William Boyde, M.A., B.Sc., D.Phil., D.Litt. ; The Rev. W. E. Brown, M.C., M.A., B.Sc., D.D. ; Lieut.-Col. T. E. Calvert ; John Dick ; Miss W. A. Donaldson, M.A. ; J. B. Frizell, B.L., A.L.A.A. ; W. A. F. Hepburn, M.C., O.B.E., LL.D., F.R.S.E. ; Andrew Hood, J.P. ; W. B. Inglis, Ed.B., Ph.D. ; Miss Margaret F. Jobson, M.A., B.Sc., J.P. ; Samuel McDonald, C.M.G., D.S.O. ; W. L. McKinlay, M.A., B.Sc., F.E.I.S. ; Miss May J. McKinlay ; Miss B. Martin Stewart ; Mrs. W. M. Monteith ; Stanley Nairne, M.A. ; S. H. Pearson ; W. Peat ; Miss E. J. Porter ; Col. W. D. Scott, D.S.O., M.C., T.D., D.L., J.P. ; The Rev. Denis E. Taylor, M.A. ; Miss Janet B. N. Thomson, M.A. ; The Rev. W. M. Wightman, D.D., F.E.I.S. ; John Wishart, M.A., F.E.I.S.

**Assessors :** T. D. Fairgrieve, M.C. (Scottish Home Department) ; Mrs. I. M. Seymour, L.R.C.P., L.R.C.S. (Department of Health for Scotland) ; W. J. Jamieson (Ministry of Labour and National Service) ; J. Macdonald (Scottish Education Department).

**Secretary :** C. H. Dand (Scottish Education Department).

#### **Terms of Reference :**

To advise the Secretary of State for Scotland on all questions affecting the welfare of Scottish youth.

### **ADVISORY COUNCIL ON THE TREATMENT OF OFFENDERS**

(Scottish Home Department)

**Chairman :** The Very Rev. C. W. G. Taylor, D.D. (Minister, St. George's Parish Church, Edinburgh).

**Members :** D. A. Anderson, J.P. (Chairman, Messrs. Caird, Ltd., Dundee, Member, Scottish Central After-care Council) ; William Barry (Headmaster, Kirkintilloch Roman Catholic School, Member, Advisory Council on Education in Scotland) ; James Campbell (Member, Scottish Trades Union Congress) ; J. Downie Campbell, J.P. (Chairman, Justice of the Peace Court, Aberdeen) ; Sir William Hamilton Fyfe, LL.D., F.R.S.C. (Principal and Vice-Chancellor, Aberdeen University, Chairman, Advisory Council on Education in Scotland) ; Councillor Margaret C. Geddes, J.P. (Chairman, Edinburgh Probation Committee) ; Sister Marie Hilda (Director, Notre Dame Child Guidance Clinic, Glasgow) ; James Macdonald, K.C. (Sheriff-Substitute, Edinburgh) ; The Rev. George MacLeod, M.C., D.D. (Chairman, Scottish Central After-care Council) ; Sir George Morton, K.C. (Member, Scottish Central Probation Committee) ; Councillor Jean Roberts, J.P. (Member, Glasgow Corporation and Police Court Judge) ; The Hon. Lord Stevenson, O.B.E., K.C. (Senator, College of Justice for Scotland, Chairman, Executive Committee of Royal Scottish Society for the Prevention of Cruelty to Children) ; Major Donald W. Sutthery (Seaforth Highlanders).

**Secretaries :** T. Maclean Martin (Scottish Home Department) ; R. T. Finlay (Scottish Education Department).

#### **Terms of Reference :**

To advise the Secretary of State on any matter connected with the treatment and rehabilitation of offenders which he may refer to the Council or which they may consider it to be expedient to bring to his notice.

### **SCOTTISH CENTRAL PROBATION COUNCIL**

(Scottish Home Department)

**Chairman :** The Hon. Lord Keith.

**Members :** D. P. Blades, K.C. ; The Hon. Mrs. Hamilton ; The Lady Margaret Kerr, J.P. ; George Lindsay ; Sir George Morton, K.C. ; Bailie Violet M. C. Robertson, C.B.E., J.P., LL.D. ; Councillor John Stewart ; A. A. Templeton ; E. W. Watt, T.D., D.L., LL.D., J.P. ; Lady Garnet Wilson.

**Terms of Reference :**

To advise the Secretary of State on any matter which he may refer to the Council, or which they may consider expedient to bring to his notice in connection with the administration of the probation service in Scotland ; to furnish the Secretary of State with information bearing on the working of the probation system in Scotland ; to consult Probation Committees and, or the National Association of Probation Officers (Scottish Branch), with Probation Officers on matters connected with the use of probation and the organisation and maintenance of an effective probation service.

**SCOTTISH CENTRAL AFTER-CARE COUNCIL**

(Scottish Home Department)

**Chairman :** The Rev. G. F. MacLeod, M.C., D.D.

**Members :** D. A. Anderson, J.P. ; George A. Anderson ; Rev. W. E. Brown, M.C., D.D. ; F. D. Cowieson ; Mrs. U. R. Crawford, J.P. ; Matthew Dick ; Brig.-Gen. R. M. Dudgeon, D.S.O., M.C. ; Councillor James Dunlop ; A. M. Estcourt ; Francis Graham, M.A. ; C. B. Hunter ; The Lady Margaret Kerr, J.P. ; R. W. Leckie ; Lieut.-Col. W. Leith-Ross, M.C. ; J. F. Montgomerie ; Mrs. J. Paterson ; Col. W. D. Scott, D.S.O., M.C., D.L. ; Major Malcolm Speir ; B. T. Stevenson, O.B.E., J.P.

**Terms of Reference :**

The assistance and supervision of persons liberated on licence from Borstal Institutions ; the assistance of discharged ordinary prisoners ; the assistance of persons liberated on licence from penal servitude ; and the assistance and supervision of persons liberated on licence from preventive detention.

**Government of Northern Ireland****HEALTH ADVISORY COMMITTEE**

(Government of Northern Ireland :

Ministry of Health and Local Government)

**Chairman :** Howard Stevenson, M.B., F.R.C.S., M.P.

**Members :** William Allen, M.B.E. ; Leslie Arndell, M.Sc. ; William J. Bailie, J.P. ; Miss M. A. Beaton, M.B.E. ; B. R. Clarke, M.C., M.D. ; Alderman Thomas L. Cole, L.P.S., J.P. ; Lieut.-Col. John M. Foreman, L.D.S. ; Lieut.-Col. A. R. G. Gordon, D.S.O., M.P. ; Councillor James Hamilton, J.P. ; Dr. J. Stuart Hawnt, M.Sc. ; J. M. Hunter, M.D. ; George G. Lyttle, M.B., M.R.C.S. ; Miss Dorothy Melville ; F. P. Montgomery, M.B. ; Councillor Patrick Murphy, J.P. ; Dr. J. H. McBurney, J.P. ; H. I. McClure, M.B., F.R.C.S., F.R.C.O.G. ; Professor W. J. Wilson, M.D., D.Sc. ; C. J. A. Woodside, M.B., F.R.C.S.

**Secretary :** John A. Oliver, B.A.

**Terms of Reference :**

To advise the Minister of Health on administration of the health and medical services.

**COMMITTEE ON YOUTH WELFARE IN  
NORTHERN IRELAND**

(Government of Northern Ireland : Ministry of Education)

**Chairman :** (Vacant).

**Members :** Edmund M. Brown ; James J. Campbell ; S. Gihon ; Mrs. M. J. I. Gilmour ; J. H. Grummitt ; Dr. J. Stuart Hawnt ; F. J. Holland ; Miss Mary Kerrigan ; Miss Anastasia McCreedy, J.P. ; Miss M. McNeill ; Miss J. G. Magill ; Mrs. Dehra Parker, O.B.E., M.P. ; Dr. Elizabeth M. Robb ; W. H. Smyth, M.B.E.

**Secretary :** W. H. N. Downer.

**Terms of Reference :**

To consider the problems affecting youth welfare in Northern Ireland and to report to the Ministry and make recommendations as to their solution.

**YOUTH COMMITTEE**

(Government of Northern Ireland : Ministry of Education)

**Chairman :** Mrs. Dehra Parker, O.B.E., M.P.

**Members :** S. McKelvey Bell ; J. J. Campbell ; Dr. J. Stuart Hawnt ; Capt. W. Johnson ; Miss Mary Kerrigan ; Mrs. Margaret McClure ; Rev. A. McGovern ; Rev. H. A. McKegney ; Miss M. E. Rankin ; Philip Smiles ; Rev. W. G. M. Thompson.

**Secretary :** W. H. Smyth, M.B.E.

**Terms of Reference :**

To conduct youth surveys, stimulate public interest in youth welfare, encourage the promotion of schemes of youth welfare, physical training and recreation and to advise the Ministry of Education, education authorities and other bodies and persons on youth welfare matters.

The Committee was appointed in February 1944, and has not yet presented any Report.

## Inter-Departmental

### INTER-DEPARTMENTAL COMMITTEE ON THE CARE OF CHILDREN

(Home Office, Ministry of Health and Ministry of Education)

**Chairman :** Miss Myra Curtis.

**Members :** Mrs. J. L. Adamson, M.P. ; Mrs. Cazalet Keir, M.P. ; H. Graham White, M.P. ; Miss S. Clement Brown ; R. J. Evans ; Miss Lucy G. Fildes ; Miss M. L. Harford ; Dr. Somerville Hastings ; Alderman Miss K. Jones ; The Rev. J. H. Litten ; J. Moss ; Mrs. Helen Murtagh ; Henry Salt, K.C. ; Professor J. C. Spence, M.C., M.D. ; Mrs. F. G. A. Temple ; S. O. Walmsley.

**Joint Secretaries :** Miss D. M. D. Rosling (Home Office) ; G. T. Milne (Ministry of Health).

**Terms of Reference :**

To inquire into existing methods of providing for children who from loss of parents, or from any other cause whatever, are deprived of normal home life with their own parents or relatives ; and to consider what further measures should be taken to ensure that these children are brought up under conditions best calculated to compensate them for lack of parental care.

### INTER-DEPARTMENTAL COMMITTEE ON SEAMEN'S WELFARE IN PORTS

(Ministry of Labour and National Service  
and Ministry of War Transport)

**Chairman :** H. Graham White, M.P.

**Members :** J. W. Booth (Chairman, Booth Steamship Co., Ltd.) ; Lieut.-Gen. G. R. S. Hickson, C.B., C.B.E. (Secretary, King George's Fund for Sailors) ; C. Jarman (Acting General Secretary, National Union of Seaman) ; R. Snedden, C.B.E. (General Manager, Shipping Federation, Ltd.) ; Captain D. S. Tennant (General

Secretary, Navigators' and Engineer Officers' Union); R. A. Witty, F.S.A.A. (President, Society of Incorporated Accountants and Auditors).

**Joint Secretaries :** J. B. W. Armstrong (Ministry of War Transport); J. W. Wellwood (Ministry of Labour and National Service).

#### **Terms of Reference :**

Having regard to the Government's acceptance of the recommendation of the International Labour Conference concerning the promotion of seamen's welfare in ports, to consider the activities and functions respectively of the Government, the shipping industry and the voluntary organisations in the establishment and maintenance of hotels, hostels, clubs, recreational facilities and other amenities for merchant seamen in ports in Great Britain, and in that connection to consider in consultation with the voluntary organisations primarily concerned with merchant seamen their appeals for funds, not only for welfare but for benevolent and samaritan purposes, whether for expenditure in Great Britain or elsewhere, and to submit recommendations.

The Report (January 1945) deals separately with the two problems involved. These are: Provision for the establishment and maintenance of hotels, hostels and clubs for seamen; and the co-ordination of appeals for funds made to the public in the name of seamen.

The satisfaction of material needs and the relief of distress are covered but spiritual welfare is considered to be outside the terms of reference although it is an integral part of the work of some of the organisations concerned with temporal welfare.

As a result of examining both the pre-war and wartime organisation for seamen's welfare, it is generally concluded that special residential and non-residential clubs for seafarers are necessary; that after the war some clubs may be redundant and that their reduction must be controlled; that the standards laid down by the Seamen's Welfare Board for clubs must be maintained as a minimum; that appeals to the public for money should be controlled; that the functions of co-ordinating and supervising the provision of clubs should be transferred from the Government to the shipping industry; and that the work of voluntary organisations should be continued, subject to the supervision of a controlling body, to registration and to control of their appeals for money.

The Committee recommends that a body should be set up to co-ordinate and control the various agencies working in the field of welfare. This Merchant Navy Welfare Board should have executive and supervisory powers over the whole field of temporal welfare, including all accommodation and recreational facilities provided by the voluntary societies. It should be a statutory body, composed of equal numbers of representatives of shipowners and of seafarers, nominated by the National Maritime Board.

The Board should create a Standing Joint Advisory Council, to advise on all questions concerning the position of the voluntary organisations.

It is proposed that Port or Regional Welfare Committees be established in all important port areas, to advise the Board on local port conditions, and to co-ordinate the welfare work in the regions. Regional Welfare Officers should act as liaison officers between the Board and the Port or Regional Welfare Committees.

The Committee recommends that powers be given to the Board to decide what clubs are required in each port, to establish new clubs and close those considered to be redundant. It should lay down standards as to type of accommodation, amenities, meals and prices to be observed in clubs and should close clubs improperly administered.

It is suggested that the Board's expenses should be met by a levy on members of the shipping industry with a contribution by the State to capital expenditure.

Special recommendations are made for the provision of licensed clubs, the admission of women guests, arrangements for married couples and younger seamen, and also for the provision of special clubs for Indian and Chinese seamen and of amenities for other seamen, especially colonial, not resident in the United Kingdom.

Only those voluntary organisations which are registered under the Board should be allowed to appeal for funds for merchant seamen or their dependants, and all appeals should require the prior approval of the Board (after consultation with the Standing Joint Advisory Council). Voluntary organisations should have the right of appeal from the Board's decisions. Co-ordination of appeals is recommended.

Finally, the Committee recommends the dissolution of the Seamen's Welfare Board. On all questions affecting the welfare of merchant seamen, Government departments should consult the Merchant Navy Welfare Board.

## ROYAL COMMISSION ON EQUAL PAY

**Chairman :** The Hon. Mr. Justice Asquith.

**Members :** John Brown ; Janet Maria ; Mrs. Gourlay, D.M., F.R.C.P. (Dr. Janet Vaughan) ; The Countess of Limerick, C.B.E. ; Dame Anne Loughlin, D.B.E. ; Miss Lucy Frances Nettlefold ; the Hon. Jasper Nicholas Ridley, O.B.E. ; Professor Dennis Holme Robertson, C.M.G., F.B.A. ; Charles Stanley Robinson, C.B.E., M.I.Chem.E.

### Terms of Reference :

To examine the existing relationship between the remuneration of men and women in the public services, in industry and in other fields of employment ; to consider the social, economic and financial implications of the claim of equal pay for equal work ; and to report.

## VOLUNTARY AID DETACHMENT (V.A.D.) STANDING COMMITTEE

**Chairman :** The Countess of Limerick, C.B.E.

**Deputy-Chairman :** The Lady Louis Mountbatten, C.B.E.

### MEMBERS :

**British Red Cross Society :** Dame Beryl Oliver, D.B.E., R.R.C. ; Mrs. Benyon ; The Countess of Eldon ; Capt. H. Ward, J.P. ; Capt. J. C. Stewart, D.L., J.P. ; F. C. Davies, O.B.E. (Secretary, B.R.C.S., *ex-officio*).

**Order of St. John :** Major P. G. Darvil-Smith, C.B.E. ; The Hon. John Bruce, D.L., J.P. ; The Hon. Mrs. Copland-Griffiths ; Miss Virginia Cunard ; Brigadier W. Barne, O.B.E., D.S.O. (Secretary-General, O. of St. J., *ex-officio*).

**Council of County Territorial Associations :** Col. His Grace The Duke of Buccleuch, G.C.V.O. ; Col. Sir William Coates, K.C.B., C.B.E.

**Secretary :** Mrs. Young.

**Terms of Reference :**

To administer the V.A.D. Scheme for the provision of members of the B.R.C.S. and the O. of St. J. for service in Naval, Military and Air Force hospitals, in accordance with regulations which may from time to time be promulgated by the Ministries concerned ; to act as the official channel between the Bodies and Service departments in all V.A.D. matters ; to arrange through the local organisations of the two Bodies for the calling up and posting of mobile V.A.D. personnel to Service formations, in accordance with requisitions received and to arrange for the maintenance of the individual records of V.A.D. members so posted, and the keeping of them up-to-date ; to administer and exercise control over the annual grant received from the constituent Bodies ; to set up a sub-committee for Scotland to administer the Committee's work in Scotland ; to appoint a Chairman and such other officers as may be necessary ; and to report to the constituent Bodies and to the C.C.T.A. at regular intervals as to the work carried out.

**Scottish Sub-Committee**

**Members :** Four representatives of the Scottish Branch, B.R.C.S. ; two of the C.C.T.A. ; one of St. Andrew's Ambulance Association, if and when that Association provides V.A.D. members.

**Terms of Reference :**

To be responsible to the Standing Committee for administering the Scheme in Scotland, and to report to it at regular intervals as to the work carried out.



The Rt. Hon. Lord Nuffield, G.B.E., O.B.E.,  
as seen by Sallan,

# Careers in Professions Associated with Health and Social Welfare

ISABELLA WILLIAMS, M.A.

## I.—MEDICINE.

The registrable qualification to practise medicine is either a bachelor degree in medicine and surgery, taken together at a university, or a diploma issued by one of the licensing corporations. Before commencing a course of medical study, a student must have passed a recognised preliminary examination in general education, normally of university matriculation or entrance standard in arts or pure science. The General Medical Council also requires an additional examination in Chemistry, Physics and one or two subjects of general education; this may be taken before or after entry to the university, but professional study cannot begin until the examination has been passed. A student must register with the University School of Medicine, and/or with the Examining Body for whose qualification he is to read.

The total length of the course at the University may not be less than five years. Part of the course includes clinical study which may be undertaken at certain recognised public hospitals or dispensaries. In some cases it is possible to take a Bachelor of Science degree concurrently. When the final examination has been passed, the student registers with the General Medical Council, which keeps the Medical Register of "legally and duly qualified medical practitioners."

### UNIVERSITY COURSES IN MEDICINE:

(Excluding those concerned solely with research and post-graduate work.)

University	Courses	Length
†Birmingham	M.B., Ch.B.; M.D.; Ch.M.; Ph.D.; M.D. (State Medicine); *D.P.H.	6 years
†Bristol	B.M., Ch.B.; Ch.M.; M.D.; Ph.D.; D.P.H.; D.V.S.M.; Testamur in Applied Bacteriology.	5 years
†Durham (King's College, Newcastle-upon- Tyne)	M.B., B.S.; M.D.; M.S.; D.Ch.; B.Hy.; D.P.H.; D.Hy.; D.Fsy.; Ph.D.	5 years
	M.B., B.S., B.D.S. (combined) .. .. .	7 years
†Leeds	M.B., Ch.B.; M.D.; Ch.M.; Ph.D. D.P.H.; D.P.M.	5½ years
†Liverpool	M.B., Ch.B.; M.D.; Ch.M.; *M.Ch.Orth.; Ph.D.; *D.M.R.E.; *D.P.H.; D.T.M.; D.T.H.; Certificate in Venereal Diseases; V.D. Pathologist Certificate.	6 years
†Cambridge	M.B., B.Chir.; M.D., M.Chir .. .. .	5 years
†London	M.B., B.S.; M.D.; M.S.; Ph.D.; D.C.P.; D.M.R.; D.P.M.; D.P.H.; Diploma in Bacteriology; Diploma in Dietetics; Clinical courses for students of Oxford and Cambridge.	5½ years

\*Indicates course temporarily suspended.



Charing Cross Hospital Medical School, 62, Chandos Place, W.C.2.  
 Guy's Hospital Medical School, London Bridge, S.E.1.  
 King's College, Strand, W.C.2.  
 King's College Hospital Medical School, Denmark Hill, S.E.5.  
 London Hospital Medical College, Turner Street, E.1.  
 London (Royal Free Hospital) School of Medicine for Women, Hunter Street, Brunswick Square, W.C.1.  
 Middlesex Hospital Medical School, W.1.  
 Queen Mary College, E.1.  
 St. Bartholomew's Hospital Medical College, E.C.1.  
 St. George's Hospital Medical School, S.W.1.  
 St. Mary's Hospital Medical School, W.2.  
 St. Thomas's Hospital Medical School, S.E.1.  
 University College, Gower Street, W.1.  
 University College Hospital Medical School, W.C.1.  
 Westminster Hospital Medical School, S.W.1.  
 (also externally).

<i>University-</i>	<i>Courses</i>	<i>Length</i>
† <b>Manchester</b>	M.B., Ch.B.; M.D.; Ch.M.; M.Sc.; D.P.M.; D.P.H.; Certificate in Venereal Diseases.	5½ years
† <b>Oxford</b>	B.A. must be obtained first; B.M., B.Ch.; D.M.; M.Ch.; D.O.	
† <b>Sheffield</b>	M.B., Ch.B.; Ch.M.; M.D. . . . .	5½ years
† <b>Wales</b>	M.B., B.Ch.; D.P.H.; T.D.D. . . . . (University College of South Wales and Monmouthshire, Cardiff; Welsh National School of Medicine, Cardiff.)	5½-6 years
† <b>Aberdeen</b>	M.B., Ch.B.; M.D.; Ch.M.; Ph.D.; D.P.H. . . . .	5 years
† <b>Edinburgh</b>	M.B., Ch.B.; M.D.; Ch.M. . . . . B.Sc. or M.A., M.B., Ch.B. (combined) . . . . . M.B., Ch.B., and any 2 other degrees . . . . . D.M.R.; *D.P.H.; D.T.M. & H.; *D.T.V.M. . . . .	5 years 7 years 8 years
† <b>Glasgow</b>	M.B., Ch.B.; M.D.; Ch.M.; D.P.H.; B.Sc. in Public Health.	5 years (6 years under new regulation)
† <b>St. Andrew's</b>	M.B., Ch.B.; M.D.; Ch.M.; *B.Sc., M.B., Ch.B. (combined); D.P.H.; D.P.D.	5 years
† <b>Belfast</b>	M.B., B.Ch., B.A.O.; M.D.; M.Ch.; M.A.O.; *D.P.H.; D.P.M.	5 years

#### NON-UNIVERSITY MEDICAL SCHOOLS:

West London Hospital Medical School.  
 Anderson College of Medicine, Glasgow.  
 St. Mungo's College, Glasgow.  
 School of Medicine of the Royal Colleges, Edinburgh.

#### LICENSING BODIES AND EXAMINATION BOARDS FOR THE CONDUCT OF EXAMINATIONS:

##### University Authorities marked "†"

##### The Examining Board in England, 8-11, Queen Square, London, W.C.1.

(Formed by the Royal College of Physicians of London and the Royal College of Surgeons of England).  
 L.R.C.P.(Lond.), M.R.C.S.(Eng.); the duple qualification gives admission to the Medical Register.  
 Post-graduate diplomas: D.P.H.; D.T.M. & H.; D.O.M.S.; D.P.M.; D.L.O.; D.M.R.D.;  
 D.M.R.T.; D.A.; D.C.H.; D.Phys.Med.

##### Scottish Conjoint Board, 18, Nicolson Street, Edinburgh, 8.

(Formed by the Royal College of Physicians of Edinburgh, the Royal College of Surgeons of Edinburgh, and the Royal Faculty of Physicians and Surgeons of Glasgow).  
 L.R.C.P. (Edin.), L.R.C.S.(Edin.), L.R.F.P. & S.(Glas.); the triple qualification gives admission to the Medical Register.  
 Post-graduate diplomas: D.P.H.

##### Society of Apothecaries, Blackfriars, London, E.C.4.

Diploma in Medicine, Surgery and Midwifery (L.M.S.S.A. Lond.).  
 Post-graduate Diploma in Obstetrics and Gynaecology (M.M.S.A.).

*Note: Where a Postal District number only is stated, this refers to London.*

## POST-GRADUATE DIPLOMA QUALIFICATIONS :

Royal College of Physicians : M.R.C.P. ; Royal College of Surgeons : F.R.C.S. ; Royal College of Obstetricians and Gynaecologists : F.R.C.O.G. ; M.R.C.O.G. ; D.R.C.O.G. ; Royal College of Physicians of Edinburgh : F.R.C.P.(Edin.) ; Royal College of Surgeons of Edinburgh : F.R.C.S.(Edin.) ; Royal Faculty of Physicians and Surgeons of Glasgow : F.R.F.P.S.(Glas.) ; Royal Institute of Public Health and Hygiene : D.P.H. (Royal Colleges of Physicians and Surgeons).

*The length of training for post-graduate diplomas and degrees varies from a number of months to two years, and in many cases hospital experience is required. The higher degrees are awarded on the results of research.*

M.B., B.M., Bachelor of Medicine ; Ch.B., B.S., B.Chir., B.Ch., Bachelor of Surgery ; B.Sc., Bachelor of Science ; B.A., Bachelor of Arts ; M.D., D.M., Doctor of Medicine ; M.S., Ch.M., M.Chir., M.Ch., Master of Surgery ; M.Sc., Master of Science ; D.Ch., Doctor of Surgery ; B.Hy., Bachelor of Hygiene ; D.Hy., Doctor of Hygiene ; B.A.O., Bachelor of Obstetrics ; M.A.O., Master of Obstetrics ; M.Ch.Orth., Master of Orthopaedic Surgery ; B.D.S., Bachelor of Dental Surgery ; Ph.D., Doctor of Philosophy ; D.A., Diploma in Anaesthetics ; D.C.H., Diploma in Child Health ; D.C.P., Diploma in Clinical Pathology ; D.L.O., Diploma in Laryngology and Otolaryngology ; D.M.R.(E.), Diploma in Medical Radiology (and Electrolaryngology) ; D.O., Diploma in Ophthalmology ; D.O.M.S., Diploma in Ophthalmic Medicine and Surgery ; D.P.D., Diploma in Public Dentistry ; D.P.H., Diploma in Public Health ; D.P.M., Diploma in Psychological Medicine ; D.Psy., Diploma in Psychiatry ; D.T.M., Diploma in Tropical Medicine ; D.T.H., Diploma in Tropical Hygiene ; D.T.V.M., Diploma in Tropical Veterinary Medicine ; T.D.D., Tuberculous Diseases Diploma.

## II.—DENTISTRY.

The Dental Board of the United Kingdom is responsible for the registration of dentists who gain the qualifications recognised by the General Medical Council. The qualification for registration is either the L.D.S. or the B.D.S. Students must register at the School of Dentistry to which they desire to be admitted, under the same conditions as for medical students. The educational standard required for entry to the L.D.S. is generally rather lower than for the degree. Professional study may be commenced either at a recognised Dental Hospital or School, or as pupil of a registered dental practitioner.

## UNIVERSITY SCHOOLS OF DENTISTRY

University	Courses	Length
†Birmingham	L.D.S. .. .. . B.D.S. ; M.D.S. .. .. .	4 years 5 years
†Bristol	L.D.S. .. .. . B.D.S. ; M.D.S. ; Ph.D. .. .. .	4 years 4½ years
†Durham (King's College, Newcastle-upon- Tyne)	L.D.S. .. .. . B.D.S. .. .. . M.B., B.S., B.D.S. (combined) M.D.S. ; Ph.D.	4 years 5 years 7 years
†Leeds	L.D.S. .. .. . B.Ch.D. ; M.Ch.D. .. .. .	4 years 5 years
†Liverpool	L.D.S. .. .. . B.D.S. ; M.D.S. ; Ph.D. .. .. .	4 years 5 years
†London	L.D.S. ; R.C.S.(Eng.) .. .. . B.D.S. .. .. . L.R.C.P.(Lond.) ; M.R.C.S.(Eng.) ; L.D.S., R.C.S.(Eng.) (combined).	4 years 4 years 7 years

Guy's Hospital Dental School, London Bridge, S.E.1.  
King's College Hospital Medical School, Denmark Hill, S.E.5.  
London Hospital Medical College, Turner Street, E.1.  
University College Hospital Medical School, W.C.1.  
Royal Dental Hospital School of Dental Surgery, W.C.2  
(also externally)

University	Courses	Length
†Manchester	L.D.S. .. B.D.S.; M.D.S.; D.D.S. .. .. .	4 years 4 years
†Sheffield	L.D.S. .. B.D.S.; M.D.S. .. .. .	4 years 5½ years
†St. Andrew's (Dental School, Dundee)	L.D.S. .. B.D.S.; M.D.S.; D.P.D.; *M.B., Ch.B., B.D.S. or L.D.S. and D.P.D. (combined).	4 years 5 years
†Belfast	L.D.S. .. B.D.S.; M.D.S. .. .. .	4 years 5 years

## NON-UNIVERSITY DENTAL SCHOOLS:

Incorporated Dental Hospital and School, 31, Chambers Street, Edinburgh, 1.  
Glasgow Dental Hospital and School, 211, Renfrew Street, Glasgow, C.3.

## LICENSING BODIES UNDER THE DENTISTS ACT, 1878 :

University Authorities marked "†"

Royal College of Surgeons of Edinburgh, 18, Nicolson Street, Edinburgh, 8.

L.D.S., F.R.C.S.(Edin.).

Royal Faculty of Physicians and Surgeons of Glasgow, 242, St. Vincent Street, Glasgow, C.2.

L.D.S., R.F.P.S.(Glas.).

Royal College of Surgeons of England, 8, Queen Square, W.C.1.

L.D.S., R.C.S.(Eng.).

L.D.S. : Licence in Dental Surgery

B.D.S., or B.Ch.D. : Bachelor of Dental Surgery.

M.D.S., or M.Ch.D. : Master of Dental Surgery.

Ph.D. : Doctor of Philosophy.

D.D.S. : Doctor of Dental Surgery.

D.P.D. : Diploma in Public Dentistry.

L.D.S., R.C.S.(Eng.) : Licence in Dental Surgery of the Royal College of Surgeons of England.

L.D.S., F.R.C.S.(Edin.) : Licence in Dental Surgery of the Royal College of Surgeons of Edinburgh.

L.D.S., R.F.P.S.(Glas.) : Licence in Dental Surgery of the Royal Faculty of Physicians and Surgeons of Glasgow.

## III.—NURSING, MIDWIFERY AND HEALTH VISITING.

## 1. NURSING :

The training of student nurses is conducted in hospitals which are recognised as training centres. The course lasts for three years, and on its successful completion and having passed the State Examinations the student's name is entered on the Register of the appropriate Nursing Council (*see below*), which administers the provisions of the Nurses' Registration Act. The Register is composed of the following parts : General Part ; Part for Male Nurses (General trained) ; Part for Mental Nurses (which includes a section for Nurses for Mental Defectives) ; Part for Sick Children's Nurses ; Part for Fever Nurses.

The General Nursing Council for England and Wales, 23, Portland Place, W.1. ; The General Nursing Council for Scotland, 5, Darnaway Street, Edinburgh, 3 ; The Joint Nursing and Midwives Council for Northern Ireland, 120, Great Victoria Street, Belfast.

The Royal College of Nursing maintains a Department of Education to provide post-certificate lectures and courses of study in every branch of nursing, to improve methods of teaching and to educate leaders for posts of responsibility. The College works in close co-operation with the leading schools of nursing and with the universities. The following courses are offered : Diploma in Nursing (University of London) ; Course for the Health Visitors' Certificate (six months) ; Sister Tutor Course (one year) ;

\*Indicates course suspended.

Dietitian Training Course (18 months); Nursing Administration Course (one year); Parentcraft Teaching Course (Part-time, two terms); Midwife Teaching Course (13 months); Industrial Nursing Course (three months, and a six weeks' course for which no certificate is offered); postal courses are also conducted.

Diplomas in Nursing are granted by the universities of London and Leeds.

Certificates of Proficiency in Mental Nursing and in the Nursing of Mental Defectives, after courses of training of three years, are granted by the Royal Medico-Psychological Association.

Nursery Nursing is a separate branch of the work. Training lasts for one to two years, and may be taken either (a) in a Nursery Training College recognised by the Association of Nursery Training Colleges, leading to the Nursery Nurse's Certificate of the Royal Sanitary Institute and the Association of Nursery Training Colleges; or (b) in a nursery recognised as a training school by the National Society of Children's Nurseries, leading to the Diploma of the Society.

## 2. MIDWIFERY :

The courses of training, conduct of examinations, issue of certificates, and the conditions of admission to the Roll of Midwives are regulated by the Central Midwives Board for England and Wales, the Central Midwives' Board for Scotland, and the Joint Nursing and Midwives Council for Northern Ireland. Pupils are registered through training institutions approved by the appropriate Board, and must generally be over twenty years of age. Training is in two parts : (a) 18 months, or six months for S.R.N.s with three years' general training; followed by (b) six months for everybody. Successful candidates are granted certificates (S.C.M.) and admitted to the Roll of Midwives. Additional courses are held for the Midwife Teachers' Certificate Examination, for S.R.N.s and S.C.M.s of three years' standing, with satisfactory experience in teaching, and refresher courses are normally organised locally.

## 3. HEALTH VISITING :

Health Visiting is concerned with the education of people in healthy living, and home visiting is the most important part of the work. Health visitors work in maternity and child welfare centres, and may also act as school nurses and tuberculosis visitors.

Students must have a good general education, and must be either (a) trained nurses with the certificate of the Central Midwives' Board (Part I), in which case the training lasts for six months\*, or (b) women who have undergone an approved course of training in public health work lasting two years, with six months' Hospital training, and who have obtained the Certificate of the Central Midwives' Board (Part I). In practice it is found that the majority of local authorities, who are the appointed authorities, require those with the nursing qualifications. Information may be obtained from the Joint Consultative Council of Institutions recognised by the Minister of Health for the Training of Health Visitors, and of Organisations of Health Visitors, 7, Victoria Street, S.W.1, and the Royal Sanitary Institute, Buckingham Palace Road, S.W.1.

*\*The Minister of Health has decided to extend the course to nine months after the war.*

Institutions recognised by the Minister of Health for the training of Health Visitors who are trained nurses :

Battersea Polytechnic, S.W.11 ; Bedford College for Women, Regents Park, N.W.1 ; Birmingham City Council ; College of Nursing, la Henrietta Place, W.1 ; Bristol City Council ; Cardiff Welsh National School of Medicine, Institute of Preventive Medicine ; County of Durham Board for the training of Health Visitors ; Essex County Council ; Hull University College ; King's College of Household and Social Science, W.8 ; Leeds University ; Liverpool School of Hygiene ; Manchester College of Technology ; National Health Society, London ; Newcastle-upon-Tyne City Council ; Shoreditch Metropolitan Borough Council ; Glasgow University ; Edinburgh University.

Approved Institutions with two-year courses :

Bedford College, Regents Park, N.W.1 ; King's College of Household and Social Science, W.8  
Battersea Polytechnic, S.W.11.

#### IV.—ANCILLARY HEALTH SERVICES.

##### 1. SANITARY INSPECTORS.

The qualifying body is the Royal Sanitary Institute and Sanitary Inspectors' Examination Joint Board, 90, Buckingham Palace Road, S.W.1, which grants a certificate. The training course lasts for six months at an approved institute, with one year of practical training, and candidates must have a general education to school certificate standard and a Health Visitors' Certificate or other approved qualification.

The Royal Sanitary Institute grants the following certificates : Certificate in Sanitary Science\* as applied to Buildings and Public Works ; certificate in Food Hygiene ; certificate for Inspectors of Meat and Other Foods\* ; certificate for Smoke Inspectors\* ; certificate in Tropical Hygiene\* for Sanitary Inspectors ; certificate in the advanced knowledge of carrying out a Sanitary Inspector's Duties\* ; certificate for Sanitary Inspectors for appointments outside England and Wales. Any certificate granted by the Institute is a qualification for associateship. Associates of seven years' standing, and those holding the above certificates marked " \* " qualify for full membership of the Institute.

##### 2. PHARMACY.

The qualifying examinations for entry to the profession of pharmacy are those leading to the qualification "Pharmaceutical Chemist" (registration under the Pharmacy Act, 1852), or the qualification of "Chemist and Druggist" (with registration under the Pharmacy Act, 1868). If a University degree in pharmacy is taken, then the student will be examined in Forensic Pharmacy only at the Pharmaceutical Chemist qualifying examination. The degree course occupies three or four years after matriculation. Before registration with the Pharmaceutical Society, it is necessary in addition to have completed a practical course of study, in an approved pharmacy or hospital, of at least 4,000 hours, either before or after the examination (if taken before, it must be under articles of pupilage).

A university degree is not a necessary qualification and a student may alternatively take the Pharmaceutical Chemist Qualifying Examination. The period of study is the same as for a degree. If the Chemist and Druggist Qualifying Examination is taken, the period is one year shorter. An examination in general education (*e.g.*, matriculation) is necessary before commencing the courses.

The registers of Pharmaceutical Chemists and of Chemists and Druggists are maintained by the Pharmaceutical Society of Great Britain, 17, Bloomsbury Square, W.C.1.

Degrees in Pharmacy may be taken at the universities of Glasgow, Leeds,

London (internal or external), Manchester and Wales (University College of South Wales and Monmouth, Cardiff). Post-qualification diplomas granted by the Pharmaceutical Society by Examination are the Diploma in Biochemical Analysis, and the Diploma in Pharmaceutical Analysis.

In addition to work in retail pharmacy, there are openings in hospitals, firms of manufacturing chemists, as public analysts under the Food and Drugs Acts, and a limited number of posts in teaching, the Navy, Civil Service, and with the staffs of pharmaceutical papers and organisations. For some of these further qualifications, such as a degree in science, may be advantageous.

### 3. MEDICAL AUXILIARIES.

The Board of Registration of Medical Auxiliaries (B.M.A. House, Tavistock Square, W.C.1) has prepared and published a register of persons properly qualified and competent to undertake various forms of treatment auxiliary to that of the medical profession. The approval of organisations and registration of members is on a voluntary basis, but the National Register of Medical Auxiliary Services contains the names of over 13,500 medical auxiliaries. These are :

(a) *Radiographers* : The qualifying body is the Society of Radiographers, 32, Welbeck Street, W.1. The training course is for two years (18 months during wartime). Radiographers are technical assistants employed in the x-ray departments of hospitals or clinics, responsible for diagnostic and therapeutic x-ray work.

(b) *Dispensing Opticians* : The qualifying body is the Association of Dispensing Opticians, 36, Cavendish Square, W.1. Candidates for the final examination must have had four and a half years of practical experience. Dispensing opticians confine their activities to dispensing the prescriptions of medical men and the manufacture of appliances.

(c) *Chiropodists* : The qualifying body is the Chiropody Group Council, B.M.A. House, Tavistock Square, W.C.1, representing the British Association of Chiropodists, Chelsea Chiropodists' Association, Chiropody Practitioners (N.I.Ch.) Limited, the Incorporated Society of Chiropodists, and the National Chiropodists' Association. The course is for two years at an approved school of chiropody. Qualified chiropodists may work in private practice, in hospitals, in municipal clinics or in welfare departments of industrial concerns.

(d) *Speech Therapists* : The qualifying body is the College of Speech Therapists, 86, Harley Street, W.1. The training course lasts for two to three years, and most qualified speech therapists work under local education authorities as part of the School Medical Service ; others work in private practice and in hospital speech clinics.

(e) *Orthoptics* : The qualifying body is the Orthoptic Board, Royal Westminster Ophthalmic Hospital, High Holborn, W.C.1. Training lasts for at least one year. The work is concerned with the development of binocular vision and the correction of muscular imbalances, and is done under the direction of an ophthalmic surgeon or general practitioner. Workers are employed in hospital and local authority clinics, or in private clinics.

(f) *Dietitians* : The qualifying body is the British Dietetic Association, 19, Porchester Square, W.2. Training depends on previous qualifications,

and is often taken by those possessing qualifications in Domestic Science, Pure Science, Nursing, or Institutional Management. The Board publishes a register of Dietitians, who may be employed in preventive medicine, curative medicine, or in educational work.

#### 4. OCCUPATIONAL THERAPISTS.

The qualifying body is the Association of Occupational Therapists, 201, Victoria House, Southampton Row, W.C.1. Occupational Therapy aims at the rehabilitation of the patient by transferring his focus of attention from himself and his disability to some external interest. The qualifying examination is the Diploma of the Association of Occupational Therapists. Candidates must have a good general education, and undergo a course of training for two and a half or three years, which may be taken at one of the following centres: Dorset House School of Occupational Therapy, Barnsley Hall Emergency Hospital, Bromsgrove, Worcester; The Occupational Therapy Centre, 12-14 Merton Rise, N.W.3; The School of Occupational Therapy, St. Andrew's Hospital, Northampton; St. Loyes School of Occupational Therapy, Newstead, Matford Avenue, Exeter.

The British Council for Rehabilitation conducts experimental courses in Rehabilitation. The Ministry of Health arranges week-end courses for doctors, fortnightly courses for masseuses, and six months' training courses in occupational therapy.

#### 5. PHYSIOTHERAPISTS.

The qualifying body is the Chartered Society of Physiotherapy, Tavistock House (North), Tavistock Square, W.C.1, which offers certificates in the following subjects: Massage and Medical Gymnastics; Electrotherapy Conjointly; Light and Electrotherapy; Electrotherapy for Blind Candidates; Hydrotherapy; Teacher of Massage and Medical Gymnastics; Teacher of Medical Electrotherapy; and Teacher of Hydrotherapy.

#### 6. OPTICIANS.

The qualifying examinations, which conform to the standard required by the Ophthalmic Benefit Approved Committee (which keeps a list of Opticians), are:

- Fellowship of the British Optical Association (F.B.O.A.);
- Fellowship of the Worshipful Company of Spectacle Makers (F.S.M.C.);
- Fellowship of the National Association of Opticians (F.N.A.O.);
- Fellowship of the Scottish Association of Opticians (F.S.A.O.);
- Membership of the Institute of Chemist-Opticians (M.I.C.O.) (for pharmacists).

#### 7. DISPENSING.

The Society of Apothecaries offers a certificate in dispensing for candidates with practical experience in pharmacy and having followed a nine months' course in Chemistry.

#### 8. HYGIENE.

The Royal Institute of Public Health and Hygiene is an examining body which issues certificates and diplomas in General Hygiene, School Hygiene, and Mothercraft and Child Welfare.

**V.—SOCIAL SERVICE.**

The social services are increasingly staffed by persons holding university degrees or diplomas or certificates in social science, and a preference is generally shown for candidates with university qualifications. In most cases the diploma or certificate is designed in such a way as to provide a suitable introduction to specialist training for one of the branches of the service, or to meet the needs of the experienced worker with little or no academic training. Training may be followed by careers in both central and local government and with voluntary organisations. They include those of factory inspectors; hospital almoners; housing managers; juvenile employment officers; psychiatric social workers; public assistance officers; welfare workers for the blind, deaf and mentally deficient; moral welfare workers; personnel managers and welfare workers in industry; wardens of settlements and community centres and youth leaders; and secretaries of relief committees and charity organisations. Information is available from the Joint University Council for Social Studies and Public Administration.

**1. CHILDREN'S CARE.**

Organisation, London County Council Training: Social Science Certificate or Diploma, including practical experience.

**2. FAMILY CASE WORK.**

Training: one year course, after Social Science Certificate, Diploma or Degree.

Family Case Workers' Association, Denison House, 296, Vauxhall Bridge Road, London, S.W.1.

**3. HOSPITAL ALMONER.**

The work of the Hospital almoner is concerned with the personal and social difficulties of patients. In addition to intensive work with patients, the almoner is concerned with arrangements for convalescent, sanatorium and other institutional treatment, after-care and comfort of the acutely and chronically ill, provision of surgical appliances, and for home nursing or supervision and the supply of extra nourishment. There are also administrative responsibilities, and general responsibilities, including participation in the social aspect of medical research, training of students, hospital policy and liaison work between the hospital and social organisation and public authorities.

Training: course of eleven months after an approved degree or diploma.

The Institute of Hospital Almoners, Tavistock House (North), Tavistock Square, London, W.C.1.

**4. HOUSING MANAGEMENT.**

Training: three years for students under 20; one to two years for women of university qualifications or useful experience.

Society of Women Housing Managers, 13, Suffolk Street, Pall Mall, London, S.W.1.



## 5. MORAL WELFARE.

Employment may be found with diocesan, moral welfare associations and committees, probation committees and other services.

Training: Social Science Certificate combined with residential courses of one and two years for women.

Josephine Butler Memorial House, 6, Abercromby Square, Liverpool, 7.

## 6. PERSONNEL MANAGEMENT AND WELFARE SUPERVISION.

Training for Personnel Management is undertaken by certain universities in collaboration with the Institute of Labour Management, Aldwych House, W.C.2, which selects students for the final stages of training and which also arranges practical training. The minimum requirement in practical work is two separate months each in a different type of industry, and experience as an operative in a factory is useful. Theoretical requirements are covered by one of the following: (a) a degree in any faculty (preferably in history, economics, commerce, sociology or modern greats), followed by one year post-graduate course in Social Science; (b) a degree which includes social science; (c) a two-year social science certificate.

## 7. PROBATION WORK.

Probation work is a personal form of social work. The probation officer supervises adult and juvenile offenders, who have been released on probation, makes investigations and reports to the Courts on the history and environment of selected cases, acts as conciliator in domestic difficulties, and helps and advises those discharged from approved schools and borstal institutions. Great importance is attached to character and personality in the selection of candidates for training by the Probation Training Board, Home Office, 59-60, Princes Gate, London, S.W.7.

Courses: (a) Social Science Certificate or Diploma, followed by a three months' course of practical work organised by the Home Office; (b) short course of six months. Appointments are made by the Home Office for London, and by magistrates in the provinces.

## 8. PSYCHIATRIC SOCIAL WORK.

Training: one year course, following a Social Science Diploma or Certificate or equivalent qualification. Workers are employed by Child Guidance Clinics and Mental Hospitals, and by organisations for defectives and delinquents. Candidates are selected for personal suitability.

## 9. YOUTH LEADERSHIP.

Training: two and a half years, including a Social Science Certificate, or one and a half years for graduates. Students are grant-aided by the Ministry of Education.

The National Association of Girls' Clubs, Hamilton House, Bidborough Street, London, W.C.1;

The National Association of Boys' Clubs, 17, Bedford Square, London, W.C.1.

## UNIVERSITY COURSES IN SOCIAL SCIENCE

<i>University</i>	<i>Courses</i>	<i>Length</i>
<b>Birmingham</b>	Diploma in Social Studies; Higher Diploma .. ..	—
<b>Bristol</b>	Testamur in Social Study; .. ..	2 years
	Higher Testamur in Social Study .. ..	3 years
<b>Durham</b>	Diploma in Youth Service .. ..	2 years
(King's College, Newcastle-upon- Tyne)	Diploma in Public Administration .. ..	2 years
	Diploma in Psychiatry .. ..	2 years
(Durham Division)	Diploma in Youth Service .. ..	1 year (part-time) (full-time)
<b>Leeds</b>	Diploma in Social Organisation and Public Service ..	2 years
<b>Liverpool</b>	B.A. with Social Science (as a special subject) .. ..	3-4 years
	Certificate in Social Science .. ..	1-2 years
<b>London</b> (Bedford College)	Certificate in Social Studies; B.A. in Sociology .. ..	2 years
(King's College of Household and Social Science)	B.Sc. Household and Social Science .. ..	3 years
<b>London</b> (School of Economics and Political Science)	Certificate in Social Science and Administration; B.A. in Sociology; .. ..	2 years
	*Diploma in Social Studies; .. ..	2 years
	Certificate in Mental Health; .. ..	10½ months
	Diploma in Sociology and Social Administration; .. ..	2 years
	Diploma in Psychology; .. ..	2 years
	Certificate in Colonial Social Studies .. ..	2 years
<b>London University</b> Extension Tutorial Classes Council	Diploma in Social Science (theory only) .. ..	—
<b>Manchester</b>	B.A. (Administration); Diploma in Social Study; .. ..	1-2 years
	Certificate in Social Administration; Diploma in Social Administration. .. ..	1-2 years
<b>University College</b> of Nottingham	Diploma in Social Studies; .. ..	2 years
	Certificate in Youth Leadership .. ..	1 year
<b>Oxford</b>	Diploma in Public and Social Administration; .. ..	2 years
	Certificate in Social Training; .. ..	1 year
	Diploma in Psychology .. ..	1 year
<b>Reading</b>	Diploma in Social Study; Certificate in Social Study ..	—
<b>University College,</b> Southampton	Diploma in Social Study; .. ..	1-3 years
	Certificate in Social Study .. ..	1 year
<b>Wales</b> (University College, Cardiff)	Diploma in Social Study and Training .. ..	1-2 years
<b>Edinburgh</b>	Diploma in Social Study; .. ..	1 year
	Certificate in Social Study; .. ..	2 years
	Certificate in Psychiatric Social Work .. ..	1 year
<b>Glasgow</b>	Diploma in Social Study .. ..	2 years
<b>Belfast</b>	Diploma in Social Studies; (theory only) .. ..	1-2 years
	Certificate in Social Studies (theory only) .. ..	1-3 years

\*Indicates course suspended.

Many of the courses outlined in this article are either being revised or under examination with a view to revision. Both medical and dental education have been reviewed by the Goodenough Committee on Medical Schools and the Teviot Committee on Dentistry respectively (*see* Section Six). Individual universities are planning post-war changes, for example, Oxford University proposes to concentrate on producing "teachers, investigators, and consultants rather than general practitioners." The Government's education and training schemes for demobilised persons will offer new facilities after the war. There is a notable trend towards increasing the length of many courses, a development which was suspended because of the war, and during wartime many special short courses have arisen and students have been admitted to training centres at a lower age than is normally required. In view of these considerations, it may be that some of the above particulars will already be out of date, and current information should be obtained from the appropriate authority.

# Directory of Organisations Interested in Health and Social Welfare

- Accidents, Royal Society for the Prevention of**, Terminal House, 52, Grosvenor Gardens, London, S.W.1. (Sloane 2246).
- Administrators of Local Government Establishments, National Association of**, 24, Abingdon Street, London, S.W.1. (Whitehall 9351).
- Adoption Society**, Chorley House, 4a, Bloomsbury Square, London, W.C.1. (Holborn 3310).
- After-Care Association (Physically Handicapped Youth)**, 2, Old Queen Street, London, S.W.1. (Whitehall 2499).
- Aged Poor Society**, 39, Eccleston Square, London, S.W.1. (Victoria 0746).
- Air Raid Distress Fund, Lord Mayor's National**, Mansion House, London, E.C.4. (Mansion House 5331).
- Analysts and Other Analytical Chemists, Society of Public**, 7 and 8, Idol Lane, London, E.C.3.
- Anthropological Institute of Great Britain and Ireland, Royal**, 21, Bedford Square, London, W.C.1. (Museum 2980).
- Apothecaries of London, Society of**, Blackfriars Lane, Queen Victoria Street, London, E.C.4. (Central 1189).
- Assistance Board**, Vicarage House, Soho Square, London, W.1. (Gerrard 7878).
- Asthma Research Council**, c/o King's College, University of London, Strand, London, W.C.2.
- Baby Welfare Council, National**, 29, Gordon Square, London, W.C.1. (Euston 2595).
- Barnardo's Homes, Dr.**, Stepney Causeway, London, E.1. (Stepney Green 3400).
- Belt Memorial Trust (for Medical Research)**; *Secretary*: Dr. A. N. Drury, Lister Institute of Preventive Medicine, Chelsea Bridge Road, London, S.W.1. (Sloane 2181).
- Birthday Trust Fund (Safer Motherhood) National**, 57, Lower Belgrave Street, London, S.W.1. (Sloane 5076).
- Blind, Greater London Fund for the**, 224, Great Portland Street, London, W.1. (Euston 5131).
- Blind, National Institute for the**, 224, Great Portland Street, London, W.1. (Euston 5251).
- Blind, National Library for the**, 35, Great Smith Street, London, S.W.1. (Abbey 2725).
- Blind Masseurs, Association of Certificated**, 204-6, Great Portland Street, London, W.1. (Euston 1062).
- Board of Control (Lunacy and Mental Deficiency)**; temporarily: Clifton Hotel, South Promenade, St. Annes-on-Sea, Lancs.
- Board of Control for Scotland, General**, York Buildings, Queen Street, Edinburgh, 2. (Edinburgh 21104).
- Boy Scouts' Association (Imperial Headquarters)**, 25, Buckingham Palace Road, London, S.W.1. (Victoria 6005).
- Boys' Brigade**, Abbey House, Victoria Street, London, S.W.1. (Abbey 5285).
- Boys' Clubs, London Federation of (Inc.)**, 222, Blackfriars Road, London, S.E.1. (Waterloo 5540).
- Boys' Clubs, National Association of, Inc.**, 17, Bedford Square, London, W.C.1. (Museum 5358).
- British Council**, 3, Hanover Street, London, W.1. (Mayfair 8484).
- British Legion**, Cardigan House, Richmond, Surrey. (Richmond 0183.)
- Brotherhood Movement (Inc.)**, Premier House, 150, Southampton Row, London, W.C.1. (Terminus 3734).
- Caldecott Community**, Hyde Heath, Wareham, Dorset. (Bere Regis 90).
- Cancer Campaign, British Empire**, 11, Grosvenor Crescent, London, S.W.1. (Sloane 5756).

- Cancer Relief, National Society for**, 47 Victoria Street, London, S.W.1; temporarily: 2, Cheam Court, Cheam, Surrey. (Vigilant 3672).
- Cancer Research Fund, Imperial**, c/o Royal College of Surgeons, Lincoln's Inn Fields, London, W.C.2. (Chancery 7820).
- Cancer Society**, 136, Harley Street, London, W.1.
- Carnegie United Kingdom Trust**, Comely Park House, New Row, Dunfermline.
- Central Bureau—Naval Officers' Charities**, *see* Naval.
- Chadwick Trust**, 204, Abbey House, Victoria Street, London, S.W.1. (Abbey 6872).
- Charities Association, British**, Kern House, 36, Kingsway, London, W.C.2. (Holborn 3282).
- Charity Commission**, The Elms, Morecambe, Lancs. (Morecambe 1387).
- Charity Organisation Society**, 296, Vauxhall Bridge Road, London, S.W.1. (Victoria 7334).
- Child Guidance Council**, 39, Queen Anne Street, London, W.1. (Welbeck 1272).
- Child Protection and Welfare Society, Catholic**, The Administrator, St. Francis' Homes, Sheffield, Beds.
- Child Psychology, Institute of**, 6, Pembridge Villas, London, W.11. (Bayswater 6248).
- Child Study Society**, 1, Gordon Square, London, W.C.1.
- Children, National Society for the Prevention of Cruelty to**, Victory House, Leicester Square, London, W.C.2. (Gerrard 2774).
- Children's Aid and Adoption Society, Homeless, and F. B. Meyer Children's Home (Inc.)**, 162, High Road, Wood Green, London, N.22. (Bowes Park 4991).
- Children's Aid Association, Invalid (London), Inc.**, Carnegie House, 117, Piccadilly, London, W.1. (Grosvenor 2178).
- Children's Aid Society**, 55, Leigham Court Road, London, S.W.16. (Streatham 2131).
- Children's Country Holidays Fund**, 18, Buckingham Street, Strand, London, W.C.2. (Temple Bar 3762).
- Children's Home and Orphanage, National**, 85, Highbury Park, London, N.5. (Canonbury 2033).
- Children's Nurseries, National Society of**, Carnegie House, 117, Piccadilly, London, W.1. (Grosvenor 1283).
- Children's Nutrition Council**, 6, East Common, Harpenden, Herts. (Harpenden 3103).
- Church Army**, 55, Bryanston Street, London, W.1. (Paddington 9211).
- Civil Defence Workers' Health Department** (of the War Organisation of Red Cross and St. John), 6, Cadogan Square, London, S.W.1. (Sloane 9951).
- Clinical Research Association**, Watergate House, York Buildings, London, W.C.2. (Temple Bar 8993).
- Commons, Open Spaces and Footpaths Preservation Society**, 71, Eccleston Square, London, S.W.1. (Victoria 9274).
- Convicts, Central Association for the Aid of Discharged, Inc.**, St. Leonard's House, 66, Eccleston Square, London, S.W.1. (Victoria 7487).
- Cookery and Food Association, Universal**, 110, Victoria Street, London, S.W.1. (Victoria 0217).
- Cripples, Central Council for the Care of**, 34, Eccleston Square, London, S.W.1. (Victoria 2928).
- County Councils Association**, 84, Eccleston Square, London, S.W.1. (Victoria 5934).
- Deaf, National Institute for the**, 105, Gower Street, London, W.C.1. (Euston 4796).
- Deaf and Dumb, Royal Association in Aid of the**, 413, Oxford Street, London, W.1. (Mayfair 3562).
- Delinquency, Institute for the Scientific Treatment of**, 17, Manchester Street, London, W.1. (Welbeck 1194-5).
- Dental Aid Fund, Ivory Cross National**, 67, Welbeck Street, London, W.1. (Welbeck 4177).
- Dental Association, British**, 13, Hill Street, London, W.1. (Grosvenor 1592).
- Dental Board of the United Kingdom**, 44, Hallam Street, London, W.1. (Langham 2804).
- Dental Service Association of Great Britain, Public, Limited**, 15, Taviton Street, London, W.C.1. (Euston 4235).

- Dermatology and Syphilology, British Association of**, 121, Harley Street, London, W.1.
- Diabetic Association**, 9, Manchester Square, London, W.1. (Welbeck 6001).
- Dietetic Association, British**, c/o Miss Simmonds, 19, Porchester Square, London, W.2. (Bayswater 5240).
- Dwellings of the Industrious Classes, Metropolitan Association for Improving the**, 44, Gordon Square, London, W.C.1. (Euston 2275).
- Economic and Social Research, National Institute of**, 53, Romney Street, Westminster, London, S.W.1. (Abbey 5292).
- Education, Central Council for Health**, Tavistock House, Tavistock Square, London, W.C.1. (Euston 3341).
- Education, Scottish Council for Health**, 3, Castle Street, Edinburgh. (Edinburgh 20020).
- Education Committees, Association of**, 10, Queen Anne Street, London, W.1. (Langham 3956).
- Education in Citizenship, Association for**, 51, Tothill Street, London, S.W.1. (Abbey 5743).
- Employment Association, Regular Forces**, 14, Howick Place, Westminster, London, S.W.1. (Victoria 7262).
- Epileptics, National Society for**, Chalfont Colony, Chalfont St. Peter, Bucks.
- Eugenics Society**, 69, Eccleston Square, London, S.W.1 (Victoria 2091).
- Ex-Services Welfare Society**, Temple Chambers, Temple Avenue, London, E.C.4. (Central 3712).
- Family Endowment Association**, 19, Wellgarth Road, London, N.W.11. (Speedwell 1294.)
- Family Planning Association**, 69, Eccleston Square, London, S.W.1. (Victoria 3368).
- Fairbridge Farm Schools** (formerly Child Emigration Society), Savoy House, Strand, London, W.C.2. (Temple Bar 6706).
- Feeble-Minded, National Association for the**, 296, Vauxhall Bridge Road, London, S.W.1. (Victoria 2694).
- Fishermen, Royal National Mission to Deep Sea**, 68, Victoria Street, London, S.W.1.; temporarily: Fishermen's Institute, Padstow, Cornwall. (Padstow 141).
- Food Education Society**, 29, Gordon Square, London, W.C.1. (Euston 3151).
- Friends, Society of**, Friends House, Euston Road, London, N.W.1. (Euston 3600).
- Girl Guides and Girl Scouts, World Association of**, 9, Palace Street, London, S.W.1. (Victoria 3674).
- Girl Guides' Association**, 17-19, Buckingham Palace Road, London, S.W.1. (Victoria 6001).
- Girls' Clubs and Mixed Clubs, National Association of**, Hamilton House, Bidborough Street, London, W.C.1. (Euston 2464).
- Girls' Friendly Society**, Townsend House, Greycoat Place, London, S.W.1. (Victoria 3254).
- Girls' Guildry**, Abbey House, Victoria Street, London, S.W.1. (Abbey 6532).
- Girls' Life Brigade**, 10, Bedford Square, London, W.C.1. (Museum 0255).
- Harvelan Society of London**, 14, Devonshire Street, London, W.1. (Welbeck 0188).
- Health, Guild of**, 8, Kensington Park Road, London, W.11. (Park 8170).
- Health, People's League of (Inc.)**, 10, Stratford Place, London, W.1. (Mayfair 0386).
- Health and Beauty, Women's League of**, *Secretary*: Miss P. St. Lo, Hope Cottage, Thorverton, Nr. Exeter.
- Health and Cleanliness Council**, Aldwych House, Aldwych, London, W.C.2. (Chancery 7319).
- Health and Hygiene, Royal Institute of Public**, 28, Portland Place, London, W.1. (Langham 2731).
- Health Centre, Pioneer, Ltd.**, Peckham; temporarily: 8K, Hyde Park Mansions, Marylebone Road, London, N.W.1. (Paddington 6358).
- Health Education, Central Council for**, *see* Education.
- Health Education, Scottish Council for**, *see* Education.
- Health Practitioners' Association**, 4, Half Moon Street, London, W.1. (Grosvenor 1122).

**Health Research Board, Industrial**, c/o London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, London, W.C.1. (Museum 3041).

**Health Society**, 136, Harley Street, London, W.1.

**Health Society, National**, 90, Buckingham Palace Road, London, S.W.1. (Sloane 3613).

**Health Workers' Council**, 5, Victoria Street, London, S.W.1. (Abbey 2784).

**Homes for the Aged Poor**, 49, St. James's Gardens, London, W.11. (Park 4332).

**Homes for Working Boys in London (Inc.)**, 6, Buckingham Street, Strand, London, W.C.2. (Temple Bar 2176).

**Homes for Working Girls in London**, 296, Vauxhall Bridge Road, London, S.W.1. (Victoria 4329).

**Homœopathic Association, British**, 43, Russell Square, London, W.C.1.

**Homœopathy, Faculty of**, The London Homœopathic Hospital, Great Ormond Street, London, W.C.1. (Terminus 3091).

**Hospital Administrators, Institute of**, 12, Grosvenor Crescent, London, S.W.1. (Sloane 7136).

**Hospital Almoners, Institute of**, Tavistock House (North), Tavistock Square, London, W.C.1. (Euston 5845).

**Hospital Fund for London, King Edward's**, 10, Old Jewry, London, E.C.2. (Monarch 2394).

**Hospital Saturday Fund**, 14-18, Holborn, London, E.C.1. (Chancery 6311).

**Hospital Saving Association (Head Office)**, 30, Lancaster Gate, London, W.2. (Paddington 7601).

**Hospital Sunday Fund, Metropolitan**, 18, Queen Victoria Street, London, E.C.4. (City 7401).

**Hospitals of Great Britain, Association of Voluntary Teaching**, c/o Guy's Hospital, London Bridge, London, S.E.1. (Hop 3500).

**Housing and Town Planning Council, National**, 41, Russell Square, London, W.C.1. (Museum 1264).

**Housing Societies, National Federation of**, 13, Suffolk Street, London, S.W.1. (Whitehall 2881).

**Howard League for Penal Reform**, *see* Penal.

**Humane Association, British**, Humanity House, Ranelagh Road, London, S.W.1. (Victoria 9246).

**Humane Society, Royal**, Watergate House, York Buildings, London, W.C.2. (Temple Bar 6879).

**Hunterian Society**; Hon. Secretaries: Alex E. Roche, F.R.C.S., 71, Harley Street, London, W.1. (Welbeck 4311); Dr. G. R. M. Cordiner, 7, Upper Wimpole Street, London, W.1. (Welbeck 4747).

**Hygiene, Association for Moral and Social**, Livingstone House, Broadway, London, S.W.1. (Whitehall 4651).

**Hygiene and Tropical Medicine, London School of**, Keppel Street, Gower Street, London, W.C.1. (Museum 3041).

**Hygiene Council, British Social (Inc.)**, 19, Tavistock Square, London, W.C.1. (Euston 4732).

**Industrial Psychology, National Institute of**, Aldwych House, Aldwych, London, W.C.2. (Holborn 2277).

**Industrial Welfare Society**, 14, Hobart Place, London, S.W.1. (Sloane 6181).

**International Labour Office**, *see* Labour.

**Invalid Kitchens of London**, 105, Clive Court, Maida Vale, London, W.9. (Cunningham 5689).

**Ivory Cross National Dental Aid Fund**, *see* Dental.

**Jewish Association for the Protection of Girls, Women and Children**, 127, Middlesex Street, London, E.1. (Bishopsgate 1639).

**Jewish Poor, Board of Guardians and Trustees for Relief of**, 127, Middlesex Street, London, E.1. (Bishopsgate 1602).

**Jewish Youth, Association for**, 17, Bedford Square, London, W.C.1. (Museum 0959).

- King Edward VII Welsh National Memorial Association**, The Temple of Peace and Health, Cathays Park, Cardiff. (Cardiff 4728).
- King George's Jubilee Trust**, 166, Piccadilly, London, W.1. (Regent 6303).
- Labour Management, Institute of**, Aldwych House, London, W.C.2. (Chancery 7541).
- Labour Office, International**, 38, Parliament Street, London, S.W.1. (Whitehall 1437).
- Legal Aid Society and Claim Assessors, Working People's**, 1, Bevington Street, London, S.E. 16.
- Leprosy Relief Association, British Empire**, 167, Victoria Street, London, S.W.1. (Victoria 5740).
- Marriage Guidance Council**, 78, Duke Street, London, W.1. (Mayfair 6787).
- Maternity and Child Welfare, National Council for**, Carnegie House, 117, Piccadilly, London, W.1. (Grosvenor 1420).
- Maternity and Child Welfare Centres and for the Prevention of Infant Mortality, National Association of**, Carnegie House, 117, Piccadilly, London, W.1. (Grosvenor 1345).
- Medical Association, British**, B.M.A. House, Tavistock Square, London, W.C.1. (Euston 2111).
- Medical Association, Socialist**, 59, New Oxford Street, London, W.C.1. (Temple Bar 1632).
- Medical Auxiliaries, Board of Registration of**, B.M.A. House, Tavistock Square, London, W.C.1. (Euston 1602).
- Medical Council, General**, 44, Hallam Street, London, W.1. (Langham 2727).
- Medical Officers, Association of Industrial**, c/o Hon. Secretary, J. Lyons & Co., Ltd., Cadby Hall, London, W.14. (Riverside 2040).
- Medical Officers of Health, Society of**, Tavistock House (South), Tavistock Square, London, W.C.1. (Euston 3923).
- Medical Officers of Schools Association**, c/o Medical Society of London, 11, Chandos Street, Cavendish Square, London, W.1.
- Medical Practitioners' Union**, 55 and 56, Russell Square, London, W.C.1. (Museum 5626).
- Medical Research, National Institute for**, Mount Vernon, Hampstead, London, N.W.3. (Hampstead 2232).
- Medical Research Council**, London School of Hygiene, Keppell Street, Gower Street, London, W.C.1. (Museum 3041).
- Medical Science and Physical Education, Research Board for the Correlation of**, *see* Research.
- Medical Society, Manchester**, The University, Manchester, 13.
- Medical Society, Royal**, 7, Melbourne Place, Edinburgh, 1.
- Medical Society of London**, 11, Chandos Street, Cavendish Square, London, W.1. (Langham 1043).
- Medical Women's Federation**, 73, Bourne Way, Hayes, Bromley, Kent (Hurstway 1904).
- Medicine, British Association of Physical**, c/o Medical Society of London, 11, Chandos Street, Cavendish Square, London, W.1.
- Medicine, Fellowship of Postgraduate**, 1, Wimpole Street, London, W.1. (Langham 4266).
- Medicine, Incorporated Liverpool School of Tropical**, Pembroke Place, Liverpool, 3.
- Medicine, Institute of Social**, 10, Parks Road, Oxford. (Oxford 48834).
- Medicine, Lister Institute of Preventive**, Chelsea Bridge Road, London, S.W.1. (Sloane 2181).
- Medicine, Royal Society of**, 1, Wimpole Street, London, W.1. (Langham 2204).
- Medicine and Hygiene, Royal Society of Tropical**, Mansion House, 26, Portland Place, London, W.1. (Langham 2127).
- Medicine in Ireland, Royal Academy of**, 6, Kildare Street, Dublin.
- Medico-Psychological Association, Royal**, 11, Chandos Street, Cavendish Square, London, W.1. (Langham 1495).



- Mental After-Care Association**, 108, Jermyn Street, London, S.W.1. (Abbey 5953).
- Mental Health, Provisional National Council for**, 39, Queen Anne Street, London, W.1. (Welbeck 1272).
- Mental Health Workers, Association of**, Grim's Dyke Cottage, Nr. Wallingford, Berks. (Wallingford 3162).
- Mental Hospital and Institutional Workers' Union**, 324, Gray's Inn Road, London, W.C.1. (Terminus 2120).
- Mental Hospitals Association**, Guildhall, London, E.C.2. (Clerkenwell 4520).
- Mental Hygiene, National Association for**, 39, Queen Anne Street, London, W.1. (Welbeck 1272).
- Methodist Temperance and Social Welfare Department**, 1, Central Buildings, London, S.W.1. (Whitehall 2638).
- Midwives, College of**, 57, Lower Belgrave Street, London, S.W.1. (Sloane 8313).
- Midwives' Board, Central**, 73, Great Peter Street, London, S.W.1. (Abbey 2414).
- Midwives' Board for Scotland, Central**, 18, Nicholson Street, Edinburgh. (Edinburgh 24748).
- Milk Publicity Council, National (Inc.)**, 33, Gordon Square, London, W.C.1. (Euston 4833).
- Miners' Welfare Commission**, Ashley Court, Ashted, Surrey. (Ashted 3242).
- Moral Welfare Committee, Catholic**, 59, Gloucester Place, London, W.1. (Welbeck 7813).
- Moral Welfare Council, Church of England**, Dacre House, Victoria Street, London, S.W.1. (Abbey 4017).
- Moral Welfare Workers, Association of**, Dacre House, Victoria Street, London, S.W.1. (Abbey 4017).
- Morality Council, Public**, 37, Norfolk Street, Strand, London, W.C.2. (Temple Bar 1483).
- Mother and Her Child, National Council for the Unmarried**, Carnegie House, 117, Piccadilly, London, W.1. (Grosvenor 1482).
- Mothercraft Training Society**, Cromwell House, Highgate Hill, London, N.6. (Mountview 2100).
- Motherhood, Women's League of Service for**, Shuttleworth Road, London, S.W.11. (Battersea 5241).
- Municipal Corporations, Association of**, Palace Chambers, Bridge Street, London, S.W.1. (Whitehall 1184).
- Naval and Royal Marine Maternity Home and Child Welfare Centre**, Royal, Beverley House, Wickham, Hants.
- Naval Officers' Charities—Central Bureau**, c/o King George's Fund for Sailors, 333, Ibex House, Minories, London, E.C.3. (Royal 4269).
- Noise Abatement League**, 105, Gower Street, London, W.C.1.
- Nuffield College**, 17, Banbury Road, Oxford. (Oxford 48323).
- Nuffield Foundation**, 73, Great Peter Street, London, S.W.1. (Abbey 2414).
- Nuffield Provincial Hospitals Trust**, 16, King Edward Street, Oxford. (Oxford 2712).
- Nursery School Association of Great Britain**, 1, Park Crescent, Portland Place, London, W.1. (Welbeck 9269).
- Nursery Training Colleges, Association of**, 8, Chester Road, Northwood, Middlesex. (Northwood 1821).
- Nurses and Midwives, Council for the Provision of Rest-Breaks Houses for**, Windsor House, Victoria Street, London, S.W.1. (Abbey 3386).
- Nurses' Association, London Scottish**, 475, Oxford Street, London, W.1. (Mayfair 1383).
- Nurses' Association, Royal British**, 194, Queen's Gate, London, S.W.7. (Kensington 0143).
- Nursing, Greater London Provident Scheme for District (The Home Nursing Scheme)**, 174, Sloane Street, London, S.W.1. (Sloane 6836).
- Nursing, Queen's Institute of District**, 57, Lower Belgrave Street, London, S.W.1. (Sloane 9948).
- Nursing, Royal College of**, 1a, Henrietta Place, London, W.1. (Langham 2646).
- Nursing and V.A.D. Services Committee, Joint**, 3, Belgrave Square, London, S.W.1.

- Nursing Association, London and District**, Holborn Hall, London, W.C.1. (Holborn 6474).
- Nursing Association, Maternity**, 63, Myddelton Square, London, E.C.1. (Terminus 4447-8).
- Nursing Association, Metropolitan District**, 31, Bedford Place, London, W.C.1. (Museum 0352).
- Nursing Council for England and Wales, General**, 23, Portland Place, London, W.1. (Langham 2819 and 3375).
- Nursing Council for Scotland, General**, 18, Melville Street, Edinburgh (Edinburgh 22938).
- Nursing in London, Central Council for District**, 25, Cockspur Street, London, S.W.1. (Whitehall 2497).
- Nursing Recruitment Centre**, 10, Old Jewry, London, E.C.2. (Langham 4362).
- Nutrition Society**, c/o Dunn Nutritional Laboratory, Milton Road, Cambridge.
- Obstetrical and Gynaecological Society, Glasgow**, Royal Maternity and Women's Hospital, Glasgow.
- Obstetrical and Gynaecological Society, North of England**; *Hon. General Secretary*: P. Malpas, F.R.C.S., 31, Rodney Street, Liverpool, 1.
- Obstetrical Society, Edinburgh**, 7, Drumsheugh Gardens, Edinburgh.
- Obstetricians and Gynaecologists, Royal College of**, 58, Queen Anne Street, London, W.1. (Welbeck 2282).
- Occupational Industries for the Physically Handicapped, Society for the Provision of**, 20, Beauchamp Place, London, S.W.3. (Kensington 3065).
- Occupational Therapists, Association of**, 201, Victoria House, Southampton Row, London, W.C.1; temporarily: 116, Liverpool Road, Chester. (Chester 2445).
- Officers' Association**, 8, Eaton Square, London, S.W.1. (Sloane 7182).
- Ophthalmic Opticians, Institute of**, 7, Park Lane, London, W.1. (Grosvenor 1578).
- Ophthalmological Society of the United Kingdom**, 5, Racquet Court, London, E.C.4.
- Opticians, Joint Council of Qualified**, 65, Brook Street, London, W.1. (Mayfair 3382).
- Orthopaedic Society, Industrial**, Manor House Hospital, Golders Green, London, N.W.11. (Speedwell 6601).
- Osteopathy, British School and Clinic of**, 16, Buckingham Gate, London, S.W.1. (Victoria 5085).
- Papworth Village Settlement**, Papworth Hall, Cambridge; London Office: 16, Grosvenor Place, London, S.W.1. (Sloane 2115); temporarily: Enham, Nr. Andover, Hants.
- Pathological Society of Great Britain and Ireland**; *Secretaries*: Professor H. R. Dean, Dept. of Pathology, The University, Cambridge; Professor J. H. Dible, British Postgraduate Medical School, Ducane Road, Shepherd's Bush, London, W.12. (Shepherd's Bush 3797).
- Penal Reform, Howard League for**, Parliament Mansions, Orchard Street, London S.W.1. (Abbey 3689).
- Pharmaceutical Society of Great Britain**, 17, Bloomsbury Square, London, W.C.1. (Holborn 8967).
- Physical Education Association**, Hamilton House, Bidborough Street, London, W.C.1. (Euston 1433).
- Physical Recreation, Central Council of**, 58, Victoria Street, London, S.W.1. (Victoria 3563).
- Physical Society**, 1, Lowther Gardens, Exhibition Road, London, S.W.7. (Kensington 0048).
- Physicians, Royal College of**, Pall Mall East, London, S.W.1. (Whitehall 7701 and 5089).
- Physicians of Great Britain and Ireland, Association of**; *Hon. Secretary*: Dr. C. E. Newman, 12, Manchester Square, London, W.1. (Welbeck 7344).
- Physiotherapy, Chartered Society of**, Tavistock House (North), Tavistock Square, London, W.C.1. (Euston 1676).
- Pilgrim Trust**, Harlech, Merioneth. (Harlech 98)
- Pioneer Health Centre, Ltd.**, *see* Health.

- Playing Fields Association, London and Greater London**, 38, Denison House, Vauxhall Bridge Road, London, S.W.1. (Victoria 0989).
- Playing Fields Association, National**, 71, Eccleston Square, London, S.W.1. (Victoria 9274).
- Police Court Mission, National**, 17, Victoria Street, London, S.W.1. (Abbey 5562).
- Police Surgeons' Association, Metropolitan**, New Scotland Yard, London, S.W.1. (Whitehall 1212).
- Prison Commission**, Kensington Mansions, Trebovin Road, Earls Court, London, S.W.5. (Frobisher 4821).
- Prisoners' Aid Societies, National Association of Discharged**, St. Leonard's House, 66, Eccleston Square, London, S.W.1. (Victoria 7487).
- Prisoners' Aid Society, Royal London Discharged**, Buckingham House, Buckingham Street, Strand, London, W.C.2. (Temple Bar 1049).
- Prisoners of War Advice Committee, Returned**, 72, Victoria Street, London, S.W.1. (Victoria 1166).
- Probation Officers, National Association of**, 47, Whitehall, London, S.W.1. (Whitehall 6867).
- Psychiatric Social Workers, Association of**, 4, The Drive, Acton, London, W.3. (Acorn 2721).
- Psycho-Analysis, Institute of**, 96, Gloucester Place, London, W.1. (Welbeck 1552).
- Psychological Society, British**, Tavistock House (South), Tavistock Square, London, W.C.1. (Euston 1620).
- Queen's Institute of District Nursing**, *see* Nursing.
- Radiographers, Society of**, 32, Welbeck Street, London, W.1. (Welbeck 7659).
- Radiologists, Faculty of**, 45, Lincoln's Inn Fields, London, W.C.2. (Chancery 6965).
- Radiology and Röntgen Society, British Institute of**, 32, Welbeck Street, London, W.1. (Welbeck 6237).
- Radium Commission**, 12, Manchester Square, London, W.1. (Welbeck 3004).
- Radium Institute**, 1-3, Riding House Street, London, W.1. (Langham 1603).
- Red Cross Society, British** (*also* War Organisation of the British Red Cross Society and Order of St. John of Jerusalem) (Head Office), 14, Grosvenor Crescent, London, S.W.1. (Sloane 5191).
- Rehabilitation, British Council for**, 32, Shaftesbury Avenue, London, W.1. (Gerrard 9415).
- Relief Abroad, Council of British Societies for**, 75, Victoria Street, London, S.W.1. (Abbey 2761).
- Relief and Rehabilitation Administration, United Nations (UNRRA)**, European Regional Office, 11, Portland Place, London, W.1. (Langham 3090).
- Research Board for the Correlation of Medical Science and Physical Education**, Hamilton House, Bidborough Street, London, W.C.1. (Euston 1086 and 1433).
- Returned Prisoners of War Advice Committee**, *see* Prisoners.
- Rheumatism Council, Empire**, 106, Finchley Road, London, N.W.3. (Hampstead 3318).
- Rural District Councils, Association of**, St. Stephen's House, Victoria Embankment, London, S.W.1. (Whitehall 6641).
- Sailors' Society (At Home and Abroad), British, Inc., Marine Officers' and Students' Hostel**, 680, Commercial Road, London, E.14. (Eastern 2967).
- St. Dunstan's**, 9-11, Park Crescent, Regent's Park, London, W.1. (Welbeck 7921).
- St. Hilda's Settlement**, 3, Old Nichol Street, London, E.2. (Bishopsgate 2619).
- St. Thomas's Welfare Centre**, 37, Royal Street, London, S.E.1. (Waterloo 4081).
- Salvation Army, International Headquarters, William Booth Memorial Training College**, Denmark Hill, London, S.E.5. (Brixton 4037).
- Sanitary Inspectors' Association**, 19, Grosvenor Place, London, S.W.1. (Sloane 1770).
- Sanitary Institute, Royal**, 90, Buckingham Palace Road, London, S.W.1. (Sloane 5134).
- Save the Children Fund**, 20, Gordon Square, London, W.C.1. (Euston 5204).

- Scientific Workers, Association of**, Hanover House, 73, High Holborn, London, W.C.1. (Chancery 5607).
- Seamen's Hospital Society**, "Dreadnought," Greenwich, London, S.E. 10. (Greenwich 1881).
- Settlements, British Association of Residential**, 32, Gordon Square, London, W.C.1. (Euston 8126).
- Settlements Association, Educational**, 8, Endsleigh Gardens, London, W.C.1. (Euston 2533).
- Seven Beliefs, Council of the**, 34, Sussex Place, London, W.2. (Paddington 7994).
- Shaftesbury Society**, 32, John Street, London, W.C.1. (Chancery 6937).
- Smoke Abatement Society, National**, Chandos House, Buckingham Gate, London, S.W.1. (Abbey 1359).
- Social Security League**, 51, Tothill Street, London, S.W.1. (Abbey 3377).
- Social Service, National Council of, Inc.**, 26, Bedford Square, London, W.C.1. (Museum 8944).
- Social Service, Scottish Council of**, 10, Alva Street, Edinburgh, 2. (Edinburgh 26418).
- Social Service, Union of Girls' Schools for (Inc.)**, U.G.S. Settlement, Staffordshire Street, Peckham, London, S.E.15. (New Cross 1823).
- Sociology, Institute of**, Le Play House, Albert Road, Malvern, Worcs. (Malvern 973).
- Soldiers', Sailors' and Airmen's Families Association**, 23, Queen Anne's Gate, London, S.W.1. (Abbey 5934).
- Soldiers', Sailors' and Airmen's Help Society**, 122, Brompton Road, London, S.W.3. (Kensington 3243).
- Speech Therapists, College of**, 86, Harley Street, London, W.1. (Langham 3622).
- Spero Fund for the Industrial Welfare of Tuberculous Persons**, *see* Tuberculous.
- Spinsters' Pensions Association, National**, 21, Scholemoore Lane, Lidget Green, Bradford.
- Surgeons in Ireland, Royal College of**, 123, St. Stephen's Green, Dublin.
- Surgeons of England, Royal College of**, Lincoln's Inn Fields, London, W.C.2. (Holborn 4699).
- Surgical Aid Society, Royal**, 1, Dorset Building, Salisbury Square, London, E.C.4. (Central 4584).
- Toc H (Talbot House) (Inc.)**, 47, Francis Street, London, S.W.1. (Victoria 0354).
- Toc H (Women's Section)**, 42, Crutched Friars, London, E.C.3. (Royal 3586).
- Townswomen's Guilds, National Union of**, 2, Cromwell Place, London, S.W.7. (Kensington 8817).
- Tuberculosis Care Office**, 75, Dynham Road, London, N.W.6. (Maida Vale 6664).
- Tuberculous Persons, Spero Fund for the Industrial Welfare of**, 296, Vauxhall Bridge Road, London, S.W.1.
- Unmarried Mother and Her Child, National Council for the**, *see* Mother.
- UNRRA**, *see* Relief.
- Urban District Councils, Association of**, 9, Bridge Street, London, S.W.1. (Whitehall 4868).
- Vegetarian Society**, Bank Square, Wilmslow, Manchester.
- Vegetarian Society, London**, 9, Adam Street, London, W.C.2. (Temple Bar 3379).
- Venerable Diseases, National Society for the Prevention of**, 49, Nassington Road, London, N.W.3. (Hampstead 2969).
- Village Centres for Curative Treatment and Training Council (Re-education of the Disabled)**, 16, Grosvenor Place, London, S.W.1. (Sloane 2115); temporarily: c/o Enham Village Centre, Andover, Hants.
- Waf's and Strays' Society**, Joel Street, Pinner, Middlesex. (Pinner 6442).
- Wellcome Research Institution**, 183-193, Euston Road, London, N.W.1. (Euston 4688-9).
- Women, National Council of**, Drayton House, Gordon Square, London, W.C.1. (Euston 3618).

- Women and Children's Protection Society**, 66, Victoria Street, London, S.W.1. (Victoria 5040).
- Women Citizen's Association, National**, 155, Denmark Hill, London, S.E. 5. (Brixton 3853).
- Women Housing Managers, Society of**, 13, Suffolk Street, London, S.W.1. (Whitehall 2881).
- Women Public Health Officers' Association**, 7, Victoria Street, London, S.W.1. (Abbey 5002).
- Women's Co-operative Guild**, 135, Leman Street, London, E.1.
- Women's Group on Public Welfare**, 26, Bedford Square, London, W.C.1. (Museum 8944).
- Women's Group on Public Welfare, Scottish**, 10, Alva Street, Edinburgh, 2. (Edinburgh 26418).
- Women's Institutes, National Federation of**, 39, Eccleston Street, London, S.W.1. (Sloane 7212).
- Women's League of Health and Beauty**, *see* Health.
- Young Men's Christian Association (National Council)**, 112, Great Russell Street, London, W.C.1. (Museum 8954).
- Young Men's Christian Association of Scotland**, 10, Palmerstone Place, Edinburgh.
- Young Women's Christian Association of Great Britain (National Offices)**, Central Building, Great Russell Street, London, W.C.1. (Museum 3532).
- Young Women's Christian Association of Scotland**, 14, Melville Street, Edinburgh.
- Youth Council, World**, 123, Grand Buildings, Trafalgar Square, London, W.C.2. (Whitehall 8580).
- Youth Hostels Association (England and Wales)**, National Office, Howards Gate, Welwyn Garden City, Herts. (Welwyn Garden 657).
- Youth Service Volunteers**, 19, Cowley Street, Westminster, London, S.W.1. (Abbey 3665).

# Statistics and Tables

TABLE 1—POPULATION

	England and Wales (Area 37,339,215 acres)	Scotland (Area 19,462,618 acres)
1821	12,000,000	2,092,000
1841	15,914,000	2,620,000
1861	20,066,000	3,062,000
1881	25,974,000	3,736,000
1901	32,528,000	4,472,000
1911	36,070,000	4,761,000
1921	37,887,000	4,882,000
1931	39,952,000	4,843,000
1939	41,460,000 (estimated)	5,007,000 (estimated)

TABLE 2—AGE COMPOSITION OF THE POPULATION  
OF ENGLAND AND WALES

1841 and 1938

Age Groups	1841	Proportions (per 100,000 persons)	1938	Proportions (per 100,000 persons)
0-4	2,106,300	13.236	2,817,600	6.836
5-9	1,904,900	11.971	2,903,100	7.044
10-14	1,732,100	10.884	3,122,300	7.576
15-19	1,586,800	9.971	3,475,300	8.432
20-24	1,550,500	9.743	3,096,500	7.513
25-29	1,282,900	8.061	3,411,500	8.277
30-34	1,167,000	7.333	3,405,200	8.262
35-39	884,500	5.558	3,203,700	7.773
40-44	888,000	5.580	2,830,000	6.866
45-49	638,600	4.013	2,660,000	6.454
50-54	634,400	3.986	2,474,500	6.004
55-59	391,800	2.462	2,284,400	5.543
60-64	439,800	2.764	1,956,000	4.746
65-69	259,600	1.631	1,517,600	3.682
70-74	224,300	1.409	1,043,400	2.532
75-79	119,900	.753	611,720	1.484
80-84	70,500	.443	286,890	.696
85 and over	32,200	.202	115,290	.280
TOTAL	15,914,100	100,000	41,215,000	100,000

TABLE 3—ANNUAL MARRIAGE, LIVE BIRTH AND  
STILLBIRTH RATES—ENGLAND AND WALES

	Persons Married per 1,000 Population of all Ages	Live Births per 1,000 Population of all Ages	Illegitimate Births per 1,000 Total Live Births	Stillbirths per 1,000 Total Births (live and still)
1841-50	16.1	32.6	—	—
1861-70	16.6	35.2	61	—
1881-90	14.9	32.4	47	—
1901-10	15.5	27.2	40	—
1911-20	16.6	21.8	48	—
1921	16.9	22.4	45	—
1922	15.7	20.4	44	—
1923	15.2	19.7	42	—
1924	15.3	18.8	42	—
1925	15.2	18.3	41	—
1926	14.3	17.8	43	—
1927	15.7	16.7	44	38*

\* Stillbirths were not registered until 1927.

TABLE 3—(continued)—ANNUAL MARRIAGE, LIVE BIRTH AND STILLBIRTH RATES—ENGLAND AND WALES

	<i>Persons Married per 1,000 Population of all Ages</i>	<i>Live Births<sup>a</sup> per 1,000 Population of all Ages</i>	<i>Illegitimate Births per 1,000 Total Live Births</i>	<i>Stillbirths per 1,000 Total Births (live and still)</i>
1928	15.4	16.7	45	40
1929	15.8	16.3	46	40
1930	15.8	16.3	46	41
1931	15.6	15.8	44	41
1932	15.3	15.3	44	41
1933	15.8	14.4	44	41
1934	16.9	14.8	43	40
1935	17.2	14.7	42	41
1936	17.4	14.8	41	40
1937	17.5	14.9	42	39
1938	17.6	15.1	42	38
1939	21.2	14.9	42	38
1940	22.7	14.6	—	36
1941	18.7	14.2	—	34
1942	17.8	15.8	54	33
1943	14.3	16.5	63	30

TABLE 4—EFFECTIVE NET REPRODUCTION RATES (APPROXIMATE)—ENGLAND AND WALES

(Calculated by the Registrar-General) (These make allowance for a continuing improvement in survivorship conditions).

<i>Year</i>	<i>Rate</i>
1933	.747
1934	.766
1935	.764
1936	.774
1937	.785
1938	.810
1939	.808
1940	.772
1941	.761
1942	.853
1943	.903

(provisional)

TABLE 5—NATURAL INCREASE AND SEX RATIO  
ENGLAND AND WALES

	<i>Mean Annual Increase by excess of Births over Deaths (per 1,000 population)</i>	<i>Male Births, per 1,000 Female Births</i>
1876-80	14.5	1,038
1881-85	14.1	1,038
1886-90	12.5	1,036
1891-95	11.8	1,036
1896-1900	11.6	1,035
1901-05	12.2	1,037
1906-10	11.6	1,039
1911-15	9.3	1,038
1916-20	5.7	1,051
1921-25	7.8	1,047
1926-30	4.6	1,043
1931-35	3.0	1,051
1936	2.7	1,054
1937	2.5	1,056
1938	3.5	1,051
1939	2.9	1,050
1940	—	1,058
1941	—	1,054
1942	—	1,061

TABLE 6—DEATH RATES—ENGLAND AND WALES

(Number of deaths per 1,000 living)

	All Ages (Standardised)	0-	5-	10-	15-	20-	25-	35-	45-	55-	65-	75-	85-	Infant Mortality*
1841-50 ...	21.58	66.0	9.05	5.29	7.48	9.29	10.30	12.9	17.0	29.9	63.6	141.5	301.0	153
1851-60 ...	21.17	67.6	8.46	4.97	7.04	8.67	9.76	12.3	16.5	28.9	61.7	139.9	296.5	154
1861-70 ...	21.34	68.6	7.99	4.49	6.42	8.21	9.83	12.7	17.4	30.4	62.8	140.4	296.6	154
1871-80 ...	20.34	63.4	6.47	3.71	5.35	7.07	8.96	12.7	17.8	31.6	65.0	142.2	308.3	149
1881-90 ...	18.62	56.8	5.30	3.03	4.37	5.63	7.56	11.5	17.1	31.4	65.0	137.6	284.0	142
1891-1900	18.07	57.7	4.34	2.51	3.73	4.74	6.40	10.5	16.8	31.5	65.0	137.2	270.8	153
1901-10 ...	15.19	46.0	3.56	2.11	2.99	3.82	5.13	8.31	14.3	28.1	58.8	127.2	260.8	128
1911-20† ...	13.51	34.6	3.60	2.28	3.32	4.29	5.47	7.41	12.6	25.0	55.8	125.5	254.2	100
1921-30 ...	10.57	22.7	2.42	1.64	2.55	3.21	3.64	5.54	10.0	21.3	50.8	120.9	260.2	72
1931 ...	10.08	19.9	2.14	1.47	2.50	3.10	3.36	5.45	9.80	20.6	50.8	123.9	268.2	66
1932 ...	9.73	19.0	2.07	1.39	2.39	3.02	3.21	4.79	9.33	20.1	49.8	121.9	264.6	65
1933 ...	9.78	17.9	2.20	1.43	2.41	3.09	3.34	5.15	9.89	20.4	49.5	123.8	266.2	64
1934 ...	9.29	17.5	2.44	1.43	2.28	2.85	3.10	4.60	9.19	19.7	47.9	113.2	236.4	59
1935 ...	9.01	16.1	2.04	1.32	2.07	2.72	2.99	4.49	8.99	19.6	47.5	114.6	245.4	57
1936 ...	9.19	17.0	1.99	1.21	1.95	2.69	2.82	4.39	9.09	20.1	48.5	118.3	265.5	59
1937 ...	9.24	16.7	1.87	1.18	1.97	2.66	2.89	4.47	9.23	20.6	49.0	120.0	271.7	58
1938 ...	8.52	15.3	1.87	1.19	1.86	2.49	2.65	4.05	8.47	19.0	45.5	110.6	240.0	53
1939† ...	8.49	13.7	1.48	1.03	1.75	2.45	2.60	3.94	8.56	19.7	47.2	119.0	260.6	50
1940† ...	9.90	15.6	1.96	1.40	2.54	3.50	3.44	4.92	10.1	22.6	52.3	130.1	279.1	56
1941 ...	9.32	—	—	—	—	—	—	—	—	—	—	—	—	59
1942 ...	8.09	—	—	—	—	—	—	—	—	—	—	—	—	49
1943 ...	8.24	—	—	—	—	—	—	—	—	—	—	—	—	49

\* Deaths under one year per 1,000 births.

† Civilian mortality only in 1915-20 and from 3rd September, 1939.

TABLE 7—DEATH RATES FROM THE PRINCIPAL DISEASES—ENGLAND AND WALES

(per million living)

	At all Ages (Standardised)						At Ages under 15 years			
	Typhoid and Para-typhoid fevers	Cerebro-spinal meningitis	Tuberculosis (all forms)	Influenza	Syphilis	Cancer	Scarlet fever	Whooping cough	Diphtheria	Measles
1851-60 ...	—	—	3,478	—	—	326	—	1,418	—	1,151
1861-70 ...	—	—	3,263	—	—	396	2,617	1,475	1,148	1,221
1871-80 ...	321	—	2,882	—	—	484	1,908	1,415	765	1,038
1881-90 ...	199	—	2,444	—	—	610	903	1,259	823	1,227
1891-1900	175	—	2,021	363	—	767	439	1,115	894	1,217
1901-10 ...	91	—	1,646	208	161	867	311	876	584	973
1911-20 ...	34	26	1,375	566	149	928	141	596	447	891
1921-30 ...	11	13	992	308	105	985	73	435	305	414
1931-40 ...	4	32	695	191	63	974	37	186	288	206

TABLE 8—NUMBER OF DEATHS FROM CERTAIN CAUSES AT ALL AGES—ENGLAND AND WALES

	Heart diseases	Cancer and other tumours	Tuberculosis (all forms)	Diseases of respiratory system	Diphtheria	Whooping cough	Scarlet fever	Measles	Syphilis	Violence	Maternal causes (excluding abortion)
1931	91,880	60,162	34,959	80,279	2,612	2,336	469	3,090	3,829	21,395	2,258
1932	93,115	61,494	32,810	71,184	2,285	2,749	461	3,205	3,674	21,694	2,213
1933	97,813	62,285	32,435	73,981	2,585	2,112	635	1,821	3,603	22,488	2,251
1934	98,514	64,016	30,124	66,619	3,990	1,906	838	3,541	3,476	22,536	2,367
1935	103,613	65,123	28,489	64,211	3,408	1,473	499	1,264	3,521	21,780	2,126
1936	112,405	66,712	27,467	70,385	3,003	1,918	440	2,593	3,432	22,428	2,011
1937	115,079	67,217	27,754	73,228	2,898	1,600	305	980	3,411	22,593	1,773



TABLE 8—(continued)—NUMBER OF DEATHS FROM CERTAIN CAUSES AT ALL AGES—ENGLAND AND WALES

	Heart diseases	Cancer and other tumours	Tuberculosis (all forms)	Diseases of respiratory system	Diphtheria	Whooping cough	Scarlet fever	Measles	Syphilis	Violence	Maternal causes (excluding abortion)
1938	116,434	68,799	25,539	59,731	2,861	1,052	311	1,524	3,463	22,564	1,742
1939	125,894	69,517	25,623	61,509	2,130	1,229	181	303	3,294	24,310	1,643
1940	136,260	70,992	28,144	83,815	2,466	678	152	855	3,198	47,205	1,372
1941	—	69,227*	28,670	—	2,641	2,383	133	1,145	—	—	1,353
1942	—	70,409*	25,549	—	1,826	799	104	458	—	—	1,360
1943	—	72,155*	25,649	—	1,370	1,114	134	773	—	—	1,297

\* Excluding non-malignant tumours and tumours of undetermined nature.

### INCUBATION AND EXCLUSION PERIODS OF THE COMMONER INFECTIOUS DISEASES

It should be understood, when this table is used, that infectious disease is a process, not an entity, and that the process is liable to modification by many circumstances. The period indicated in the second and third columns of this table should, therefore, be regarded as approximate only. Just as infectious diseases behave differently in different individuals, so epidemics behave differently in different types of area. The medical officer of health or school medical officer must therefore decide how far the suggestions contained in the appendix are applicable to local conditions and what are the best measures of control in his own area. It is, however, the opinion of the Ministry and the Board that the Rules governing exclusion of contacts should not be more rigid than those suggested in the appendix.

	Usual Incubation Period (days)	Interval between onset and appearance of rash (days)	Period of Exclusion	
			Patients	Contacts, i.e., the other members of the family or household living together as a family, that is, in one tenement
SCARLET FEVER	1-7	1-2	7 days after discharge from hospital or from home isolation (unless "cold in the head," discharge from the nose or ear, sore throat, or "septic spots" be present).	7 days after the removal of the patient to hospital or the beginning of his isolation at home.
DIPHTHERIA	2-7	—	Until pronounced by a medical practitioner to be free from infection.	7 days after the removal of the patient to hospital, or the beginning of his isolation at home. If there be any suspicious signs the child should be excluded further until pronounced by a medical practitioner to be free from infection.
MEASLES ..	7-14	3-4	14 days after the appearance of the rash if the child appears well.	Infants who have not had the disease should be excluded for 14 days from the date of appearance of the rash in the last case in the house. Other contacts can attend school. Any contact suffering from a cough, cold, chill or red eyes should be immediately excluded.
GERMAN MEASLES	5-21	0-2	7 days from the appearance of the rash.	None.

	Usual Incubation Period (days)	Interval between onset and appearance of rash (days)	Period of Exclusion	
			Patients	Contacts, i.e., the other members of the family or household living together as a family, that is in one tenement
WHOOPING COUGH	6-18	—	28 days from the beginning of the characteristic cough.	Infants who have not had the disease should be excluded for 21 days from the date of onset of the disease in the last case in the house.
MUMPS ..	12-28	—	14 days from the onset of the disease or 7 days from the subsidence of all swelling.	None.
CHICKENPOX	11-21	0-2	14 days from the date of the appearance of the rash.	None.
*SMALLPOX	10-21	3	Until the patient is pronounced by a medical practitioner to be free from infection.	21 days unless recently successfully vaccinated when exclusion is unnecessary.

\* The incubation period of major smallpox is commonly 12 days but that of minor smallpox is more variable and the wide limits given apply to this variety of the disease.  
 [The above table is an extract from the "Memorandum on Closure of and Exclusion from School," printed and published by His Majesty's Stationery Office.]

TABLE 9—NOTIFICATIONS OF CERTAIN INFECTIOUS DISEASES—ENGLAND AND WALES

(Case rates per 1,000 population : 1939 and 1940 civilians only)

	Enteric fever	Cerebro-spinal fever	Scarlet fever	Diphtheria	Whooping cough	Erysipelas	Dysentery	Measles	Acute Poliomyelitis and Polio-encephalitis	Puerperal fever and Puerperal pyrexia
1931	0·06	0·05	2·05	1·26	—	0·38	—	—	0·01	0·20
1932	0·06	0·05	2·12	1·08	—	0·36	—	—	0·02	0·19
1933	0·04	0·04	3·21	1·18	—	0·45	—	—	0·02	0·20
1934	0·03	0·03	3·76	1·70	—	0·51	—	—	0·02	0·21
1935	0·04	0·02	2·96	1·60	—	0·42	—	—	0·02	0·20
1936	0·06	0·02	2·53	1·39	—	0·40	—	—	0·01	0·20
1937	0·05	0·03	2·33	1·49	—	0·37	0·10	—	0·02	0·22
1938	0·03	0·03	2·41	1·58	—	0·40	0·10	—	0·04	0·23
1939	0·04	0·04	1·89	1·15	—	0·34	0·05	—	0·02	0·22
1940	*	0·28	1·60	1·14	1·34	0·32	0·07	10·19	0·03	0·19

\* 1940 : Typhoid fever 0·02 ; Paratyphoid fever 0·05.

TABLE 10—PRINCIPAL NOTIFIABLE DISEASES—ENGLAND AND WALES. NUMBER OF NOTIFIED CASES

Diseases	Cases (including Non-civilians)			
	1940	1941	1942	1943
Cerebro-spinal Fever .. .. .	12,771	11,077	6,029	3,303
Continued and Relapsing Fever ..	10	6	3	6
Diphtheria (including Membranous Croup)	46,281	50,797	41,404	34,662
Dysentery .. .. .	2,860	6,670	7,296	7,905
Encephalitis Lethargica (Acute) ..	211	187	148	109

TABLE 10—(continued)—**PRINCIPAL NOTIFIABLE DISEASES—ENGLAND AND WALES. NUMBER OF NOTIFIED CASES**

Diseases	(Cases (including Non-civilians))			
	1940	1941	1942	1943
Enteric Fever (including Paratyphoid Fevers) .. .. .	2,833	4,763	858	713
Erysipelas .. .. .	13,123	12,237	11,598	11,833
Malaria* .. .. .	2*	2*	2*	4*
Measles .. .. .	409,521	409,715	286,341	376,104
Ophthalmia Neonatorum .. .. .	4,390	4,195	4,516	4,502
Plague .. .. .	—	—	—	—
Pneumonia† .. .. .	47,875	50,942	42,698	52,407
Polio-encephalitis (Acute) .. .. .	128	83	93	46
Poliomyelitis (Acute) .. .. .	951	876	581	410
Puerperal Pyrexia‡ .. .. .	7,627	7,356	8,542	8,354
Puerperal Sepsis‡ .. .. .	65,302	59,432	85,084	116,033
Scarlet Fever .. .. .	—	—	—	—
Smallpox .. .. .	1	—	7	—
Tuberculosis (all forms) § .. .. .	46,572	50,964	52,619	54,342
Typhus .. .. .	—	—	—	—
Whooping Cough .. .. .	53,607	173,331	66,016	96,136

\* Contracted in England and Wales.

† Including influenza with pneumonic complications.

‡ Cases of Puerperal Sepsis notifiable as puerperal pyrexia for all areas (outside London Administrative County) from 1st October, 1937.

§ Formal notification: Number of new cases included in annual returns furnished by local authorities.

TABLE 11—**VENEREAL DISEASE**

Number of cases dealt with at treatment centres in England and Wales\*

Year	Syphilis	Soft Chancre	Gonorrhoea	Total V.D.	Other than V.D.	Total
1940 ..	16,379	997	31,438	48,814	33,213	82,027
1941 ..	21,138	1,156	38,173	60,467	36,423	96,890
1942 ..	28,509	1,145	34,796	64,450	43,621	108,071
1943 ..	30,697	902	33,875	65,474	72,712	138,186

\* Includes cases transferred from centre to centre and those that returned after being struck off the books in previous years.

TABLE 12—**BIRTH RATES FOR PRINCIPAL BRITISH AND FOREIGN COUNTRIES IN 1939**

(Number of live births per 1,000 population)

England and Wales ..	14.9	France ..	14.6	Sweden ..	15.3
Scotland ..	17.4	Germany ..	20.3	Switzerland ..	15.2
Northern Ireland ..	19.5	Hungary ..	19.6	Australia ..	17.7
Eire ..	19.1	Italy ..	23.5	Canada ..	20.3
Austria ..	20.9	Netherlands ..	20.6	New Zealand ..	18.7
Belgium ..	15.3	Norway ..	15.9	South Africa (Whites)	25.3
Czechoslovakia ..	16.8*	Portugal ..	26.4	United States ..	17.3
Denmark ..	17.9	Roumania ..	28.3	Japan ..	26.7*
Finland ..	18.9†	Spain ..	16.2		

\* 1938

† 1937

TABLE 13—**INFANT MORTALITY—INTERNATIONAL COMPARISONS**

(Deaths under one year per thousand live births)

Country	1939	1940	1941	1942	1943
Australia .. ..	38	38	40	—	—
Belgium .. ..	73	85	84	78	—
Canada .. ..	61	56	60	54	—
Denmark .. ..	58	50	55	—	—
Eire .. ..	66	66	74	68	—
England and Wales ..	50	55	59	49	49
France* .. ..	63	91	73	70	—
Germany† .. ..	60	63	63	66	—
Holland .. ..	34	39	43	40	—
India‡ .. ..	167 (1938)	—	—	—	—
Italy .. ..	97	103	116	108	—
Japan .. ..	114 (1938)	—	—	—	—
New Zealand   ..	42	37	40	—	—
Northern Ireland ..	70	86	77	76	—
Scotland .. ..	69	78	83	69	65
Spain .. ..	135	109	143	—	—
Sweden .. ..	39	39	37	—	—
Switzerland .. ..	43	46	41	38	—
United States§ ..	48	47	45	40	—

\* Excluding Alsace-Lorraine.

† 1937 boundaries.

‡ British India including Burma.

|| Including Maoris.

§ Including coloured population.

TABLE 14—**EXPECTATION OF LIFE AT DIFFERENT AGES—  
ENGLAND AND WALES**

Age	Males				Females	
	English Life Table 8	English Life Table 9	English Life Table 10	English Life Table 8	English Life Table 9	English Life Table 10
	1910-12	1920-22	1930-32	1910-12	1920-22	1930-32
0 ..	51.50	55.62	58.74	55.35	59.58	62.88
10 ..	53.08	54.64	55.79	55.91	57.53	58.87
20 ..	44.21	45.78	46.81	47.10	48.73	49.88
30 ..	35.81	37.40	38.21	38.54	40.26	41.22
40 ..	27.74	29.19	29.62	30.30	31.86	32.55
50 ..	20.29	21.36	21.60	22.51	23.69	24.18
60 ..	13.78	14.36	14.43	15.48	16.22	16.50
70 ..	8.53	8.75	8.62	9.58	9.95	10.02
80 ..	4.90	4.93	4.74	5.49	5.56	5.46
90 ..	2.87	2.82	2.63	3.16	3.13	2.98

TABLE 15—**MINISTRY OF LABOUR'S COST-OF-LIVING INDEX**

(Prices at July, 1914 = 100)

Date	Food	Rent and Rates	Clothing	Fuel and Light	Other Items	Total
September 1st, 1939 ..	138	162	205-210	180-185	180	155
July 1st, 1941 ..	167	164	375	228	227	199
January 1st, 1942 ..	163	164	400	230	233	200
January 1st, 1943 ..	164	164	370	244	268	199
April 1st, 1943 ..	165	164	355	244	268	199
January 1st, 1944 ..	168	164	340-345	244	291	199
Percentage increase:						
January 1st, 1944 over September 1st, 1939..	22	1	64	34	63	28

TABLE 16—MATERNITY AND CHILD WELFARE

	England	Wales	Total 1943	Total 1942	Total 1941	Total 1935
Local authorities' infant-welfare centres open on 31st December, 1943 .. ..	2,665	329	2,994	2,893	2,832	2,490
Voluntary associations' infant-welfare centres open on 31st December, 1943 .. ..	825	6	831	819	796	813
Local authorities' ante-natal clinics open on 31st December, 1943 .. ..	1,529	158	1,687	1,651	1,618	1,311
Voluntary associations' ante-natal clinics open on 31st December, 1943 .. ..	252	0	252	255	262	285
Women who attended ante-natal clinics during 1942, or received ante-natal care through welfare authorities' arrangements with private practitioners. (Total for England and Wales represents 77% of total registered births in 1943) ... ..	512,780	29,397	542,177	513,325	452,867	288,079
Local authorities' post-natal clinics open on 31st December, 1943 .. ..	791	2	793*	764	707	385
Voluntary associations' post-natal clinics open on 31st December, 1943 .. ..	100	0	100	105	105	84
First visits during 1942 by health visitors to children under one year. (Total for England and Wales represents 96.8% of total registered live births in 1943) ...	619,590	42,039	661,629	631,317	566,068	584,645
Visits during 1943 by health visitors to children between one and five years ... ..	4,240,166	278,925	4,519,091	4,582,825	4,637,841	4,407,415
Children who attended infant-welfare centres in 1942, over one year of age on 31st December, 1943... ..	654,903	47,333	702,236	686,899	685,880	Not available
Under one year who attended for first time in 1942. (Total for England and Wales represents 68.7% of total registered live births in 1943)	436,902	32,422	469,324	453,467	409,489	351,149

\* In addition post-natal examinations are frequently made at ante-natal clinics.

TABLE 17—WARTIME NURSERIES

	Whole-time		Part-time	
	31st March, 1943	31st March, 1942	31st March, 1943	31st March, 1942
Nurseries open .. ..	1,096	258	136	145
Nurseries in preparation ..	393	454	6	61
Total .. ..	1,489	712	142	206

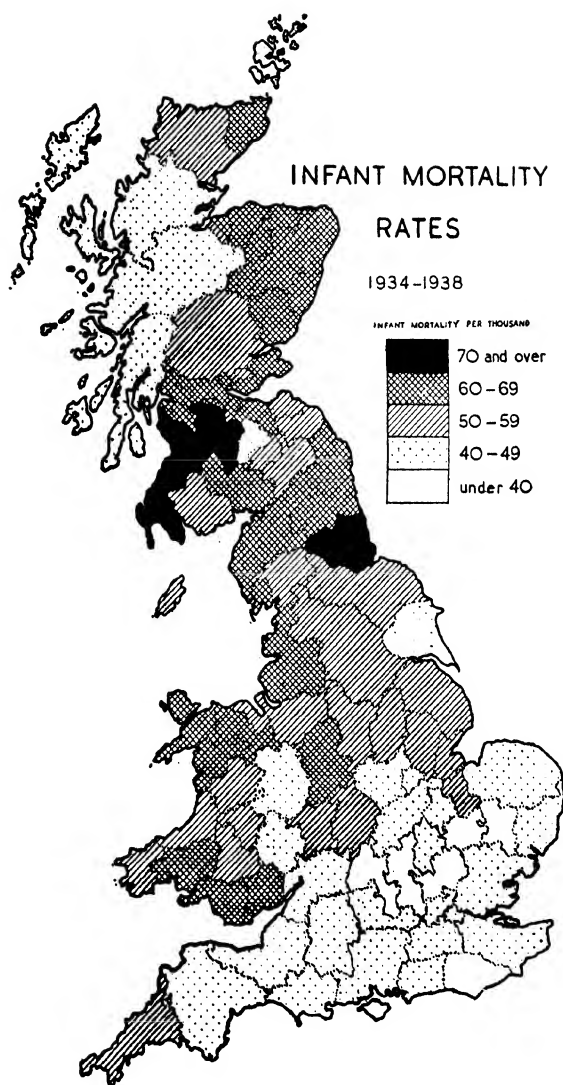
**GENERAL GUIDE TO OFFICIAL (AND OTHER PUBLISHED)  
STATISTICS**

<i>Nature of Information Sought</i>	<i>Country</i>	<i>Source</i>
Vital statistics (populations, births, marriages, deaths, etc.).	England and Wales	Registrar-General for England and Wales. Annual Reviews (Medical, Text and Civil), Weekly and Quarterly Returns and Census Reports.
Vital statistics (populations, births, marriages, deaths, etc.).	Scotland .. ..	Registrar-General for Scotland. Annual Report, Weekly and Quarterly Returns and Census Reports.
Vital statistics (populations, births, marriages, deaths, etc.).	Northern Ireland..	Registrar-General for Northern Ireland. As previous entry.
Vital statistics (populations, births, marriages, deaths, etc.).	Eire .. ..	Registrar-General for Eire. As previous entry.
Vital statistics (populations, births, marriages, deaths, etc.).	International ..	Annual Year Books published by League of Nations.
Occupational statistics ..	England and Wales	Registrar-General's Census Report for 1931 (Part IIA) and corresponding volumes for previous censuses.
Parliamentary electors and local government electors on the 1939 Register.	England and Wales	Registrar-General's Annual Review (Part Civil).
Changes in local government boundaries.	England and Wales	Registrar-General's Annual Review (Part Civil).
Cost of living, wage changes, hours of work and industrial conditions generally.	Britain .. ..	Ministry of Labour Gazette.
Unemployment Insurance..	Britain .. ..	Reports of the Unemployment Insurance Statutory Committee.
Unemployment, legislation, transference, training, and welfare.	Britain .. ..	Annual Reports of the Ministry of Labour.
Industrial conditions, accidents, time and movement study.	Britain .. ..	Special Reports by Industrial Health Research Board.
Industrial Assurance ..	Britain .. ..	Annual Reports of the Industrial Assurance Commissioner.
National Health Insurance Fund.	England and Wales	Annual Accounts of Fund
Pensions .. ..	England and Wales	Annual Reports of Ministry of Pensions.
Friendly Societies .. ..	England and Wales	Annual Reports of the Chief Registrar of Friendly Societies.
Factory and Workshop Acts.	England and Wales	Annual Reports of Chief Inspector of Factories (Ministry of Labour).
Mining conditions .. ..	England and Wales	Annual Reports of Inspector of Mines (Ministry of Fuel).
Miners' welfare .. ..	England and Wales	Annual Reports of Miners' Welfare Fund.

**GENERAL GUIDE TO OFFICIAL (AND OTHER PUBLISHED)  
STATISTICS**

<i>Nature of Information Sought</i>	<i>Country</i>	<i>Source</i>
Local Government Financial Statistics.	England and Wales	Ministry of Health's Annual Reports: Local Government Financial Statistics, Parts I, II, III and Summary.
Financial statistics for poor-law, and general hospitals, sanatoria, maternity homes, poor-law institutions, children's homes, etc.	England and Wales	Ministry of Health's Annual Costing Returns, Parts I, II and III.
Financial statistics for mental hospitals and institutions.	England and Wales	Board of Control's Annual Costing Returns.
Poor-relief finance .. ..	England and Wales	Ministry of Health's Local Government Financial Statistics, Part I.
Poor-relief statistics ..	England and Wales	Ministry of Health Return, Persons in Receipt of Poor Relief.
Rates and rateable values..	England and Wales	Ministry of Health Report, Rates and Rateable Values.
Expenditure on the public social services.	England, Wales and Scotland.	Treasury Return, Public Social Services.
Housing statistics .. ..	England and Wales	Ministry of Health Annual Report, Housing.
Public Health .. ..	England and Wales	Annual reports of Ministry of Health and Annual Reports of Chief Medical Officer of the Ministry.
Public health (special reports)	Britain .. ..	Special Series of Reports issued by Medical Research Council.
Mental Health .. ..	England and Wales	Annual Reports of Board of Control.
Midwives .. ..	England and Wales	Annual Reports of the Central Midwives Board.
Education services.. ..	England and Wales	Annual Reports of Board of Education.
Cost of Education .. ..	England and Wales	Annual Costing Returns of Board of Education.
School medical service and school meals.	England and Wales	Annual Reports of the Chief Medical Officer of the Board of Education.
Hospital statistics .. ..	England and Wales	Hospitals Year Book.
Voluntary organisations ..	Britain .. ..	Annual Charity Register.
Juvenile courts, approved and remand homes, and juvenile delinquency.	England and Wales	Reports on the Work of the Children's Branch of the Home Office.
Prisons .. ..	England and Wales	Annual Reports of the Commissioners of Prisons.
Public libraries .. ..	England and Wales	Annual Reports of Public Libraries.
General national statistics	United Kingdom ..	Annual Statistical Abstract for the United Kingdom.

NOTE.—In most cases cited there is a corresponding report issued by the appropriate Scottish Department.





## LIST OF REPORTS

*The following Reports—obtainable from the H. M. Stationery Office—mentioned elsewhere in this book, are detailed below so that readers may obtain copies of the unabridged versions.*

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**Ministry of Health.** First Report of the Nurses Salaries Committee, 1943. (Reprinted 1944) Cmd. 6424, 9d. Second Report of the Nurses Salaries Committee, 1943. (Reprinted 1944). Cmd. 6487, 9d. Nurses Salaries Committee: Report of the Mental Nurses Sub-Committee. 1944. Cmd. 6542, 9d. Nurses and Midwives Salaries Committees: Report of the Joint Superannuation Committee on the Superannuation of Nurses and Midwives. 1945. Cmd. 6603. 9d. Report of Midwives Salaries Committee. 1943. Cmd. 6460. 6d. Hostels for 'Difficult' Children: A survey of experience under the evacuation scheme. 1944. 6d. Report of the Interdepartmental Committee on Medical Schools (Goodenough Committee). 1944. 4s. 6d. Interdepartmental Committee on Dentistry (Teviot Committee). Interim Report 1944. Cmd. 6565. 6d.

**Ministry of Education.** Teachers and Youth Leaders (Report of the McNair Committee). 1944. 2s. Post-War Youth Service in Wales (Report of the Welsh Youth Committee). 1945. 4d. The Youth Service after the War: Report of the Youth Advisory Council. 1943. 6d.

**Ministry of Fuel and Power.** Twenty-second Annual Report of the Safety in Mines Research Board. 1943. 1944. 1s.

**Home Office.** Workmen's Compensation: Interim Report of the Departmental Committee on Alternative Remedies. 1945. Cmd. 6580. 2d. London County Council Remand Homes: Report of the Committee of Inquiry. 1945. Cmd. 6594. 6d.

**Ministry of Labour and National Service and Ministry of War Transport.** Seamen's Welfare in Ports: Report of the White Committee, 1943. 1945. 9d.

**Department of Health for Scotland.** Scottish Nurses Salaries Committee (Taylor Committee). Second Report. 1943. 6d.

## Books, Periodicals and Films

### Books

THE following bibliography is intended as a guide to reading for those interested in health and social welfare and is not meant to be exhaustive. Due to wartime conditions certain books are out of print, but are listed so that readers may consult them in reference libraries.

All prices are nett and subject to alteration. The dates quoted are, as far as possible, of the latest revised editions.

#### Education

- Adams, John. *Modern Developments in Educational Practice*. (University of London Press) 1938. 6s. 6d.  
 Campbell, A. E. and Bailey, C. L. *Modern Trends in Education*. (Oxford University Press) 1938. 10s.  
 Coade, T. F. *Manhood in the Making*. (Davies) 1939. 5s.  
 De La Chalotais, L. R. *Essay on National Education*. (Edward Arnold) 1934. 6s.  
 Dent, H. C. *Education in Transition*. (Kegan Paul) 1943. 12s. 6d.; *A New Order in English Education*. (University of London Press) 1942. 3s. 6d.  
 Kandel, I. L. *History of Secondary Education*. (Harrap) 1932. 12s. 6d.  
 Kennedy-Fraser, D. *Education of the Backward Child*. (University of London Press) 1932. 5s.  
 Le Mesurier. *Boys in Trouble*. (Murray) 1939. 3s. 6d.  
 Leybourne, C. G. and White, K. *Education and the Birth-rate*. (Cape) 1940. 10s. 6d.  
 Norwood, C. *The English Tradition of Education*. (Murray) 1929. 10s. 6d.  
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 Blacker, C. P. *A Social Problem Group*. (Oxford University Press) 1937. 15s. Out of print. *Voluntary Sterilization*. (Oxford University Press) 1934. 5s. Out of print.  
 Blacker, C. P. (Editor). *The Chances of Morbid Inheritance*. (Lewis) 1934. 15s.  
 Cole, Estelle. *Education for Marriage*. (Duckworth) 1938. 3s. 6d.  
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- Drew, John. *Human Reproduction and Venereal Disease*. (Faber & Faber) 1944. 3s. 6d.
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- Ellis, Havelock. *Sex in Relation to Society*. (Heinemann) 1945. 21s. Second Edition.
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- Fisher, R. A. *The Genetical Theory of Natural Selection*. (Oxford University Press) 1930. 17s. 6d.
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- Glass, D. V. *The Struggle for Population*. (Oxford University Press) 1936. 7s. 6d.
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- Hogben, L. *Genetic Principles in Medicine and Social Service*. (Allen & Unwin) 1931. 15s.
- Holmes, S. J. *Human Genetics and its Social Import*. (McGraw-Hill) 1936. 24s. 6d. Out of print.
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- McCleary, G. F. *The Menace of British Depopulation*. (Allen & Unwin) 1937. 4s. 6d.
- Miller, E. *The Generations*. (Faber & Faber) 1938. 7s. 6d.
- Newman, Sir George. *Health and Social Evolution*. (Allen & Unwin) 1930. 4s. 6d.
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- Ray, Randolph. *Marriage is a Serious Business*. (Hodder & Stoughton) 1944. 5s.
- Scheinfeld, A. *You and Heredity*. (Chatto & Windus) 1939. 10s. 6d.
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- Sutherland, H. *Control of Life*. (Hollis) 1943. 10s. 6d.
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- Abrahams, A. and Widdowson, E. M. *Modern Dietary Treatment*. (Baillière, Tindall & Cox) 1940. 10s. 6d.
- Bacharach, A. L. *Science and Nutrition*. (Watts) 1938. 2s. 6d.
- Barclay, A. E. *The Digestive Tract*. (Cambridge University Press) 1936. 40s.
- Bogert, L. J. *Nutrition and Physical Fitness*. (Saunders) 1943. 18s.
- Bourne, G. *Nutrition and the War*. (Cambridge University Press) 1942. 4s. 6d.

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- Cooper, L. F. Barber, E. M. and Mitchell, H. S. *Nutrition in Health and Disease*. (Lippincott) 21s. Ninth Edition.
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- McDonald, W. *Food Facts and Diet Planning*. (Macmillan) 1938. 3s. 6d.
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### Health Education

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- Guirdham, Arthur. *Disease and the Social System*. (Allen & Unwin) 10s. 6d.
- Hill, T. W. *The Health of England*. (Cape) 1933. 4s. 6d.
- Horder, Lord. *Health and a Day*. (Dent) 1937. 5s.; *Rheumatism : A Plan for National Action* (in collaboration with the Empire Rheumatism Council) (Lewis) 1944. 2s. Fourth Edition.
- Jephcott, A. P. *Girls Growing Up*. (Faber & Faber) 1942. 6s.
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- Kirk, J. Balfour. *A Manual of Practical Tropical Sanitation*. (Baillière, Tindall & Cox) 1937. 8s. 8d.
- Krueger, W. W. *Fundamentals of Personal Hygiene*. (Saunders) 1944. 10s. 6d.
- Laird, S. M. *Venereal Disease in Britain*. (Penguin Books) 1943. 9d.
- Layton, T. B. *An Industry of Health*. (Heinemann) 1944. 3s. 6d. Second Edition.
- Little, W. B. *Science and Health*. (Pitman) 1940. 2s. 9d.
- Mackintosh, J. M. *The Health of Scotland*. (Oliver & Boyd) 1943. 1s.
- McNally, C. E. *Public Ill Health*. (Gollancz) 1935. 5s.
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- Masters, David. *Conquest of Disease*. (John Lane) 1925. 8s. 6d. Out of Print.
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- Maxwell, James. *The Care of Tuberculosis in the Home*. (Hodder & Stoughton) 1943. 7s. 6d.
- Murray, Stark D. *Health for All*. (Gollancz) 1943. 6s.
- Newman, Sir George. *The Building of a Nation's Health*. (Macmillan) 1939. 21s.
- Newsholme, Sir Arthur. *Fifty Years in Public Health*. (Allen & Unwin) 15s.; *Last Thirty Years in Public Health*. (Allen & Unwin) 15s.
- Newsholme, H. P. *Health, Disease and Integration*. (Allen & Unwin) 12s. 6d.
- Notter, J. L., Firth, R. H., Adam, L. C. and Boome, E. J. *Hygiene*. (Longmans Green) 1940. 12s. 6d.
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- Pearse, Innes and Crocker, Lucy H. *The Peckham Experiment*. (Allen & Unwin) 1943. 12s. 6d. Fourth Edition.
- Roberts, Llewelyn. *Aids to Public Health*. (Baillière, Tindall & Cox) 1941. 6s. Fourth Edition. Fifth Edition in preparation.
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- Savage, Sir W. *Practical Public Health Problems*. (Churchill) 1941. 10s. 6d.

- Scharlieb, Mary. *Change of Life*. (Faber & Faber) 1941. 3s.  
 Scott, G. W. Ryley. *Secrets of Keeping Healthy and Living Long*. (Watts) 1943. 5s.  
 Sekulich, M. *What is Tuberculosis?* (Heinemann) 1945. 3s. 6d.  
 Smith, R. C. F. *Hygiene for Schools*. (Blackie) 1938. 8s. 6d.  
 Soule, Elizabeth and MacKenzie, Christine. *Community Hygiene*. (Macmillan) 1941. 10s.  
 Taylor, F. S. *The Conquest of Bacteria*. (Secker & Warburg) 1940. 6s.  
 Turner, C. E. *Personal and Community Health*. (Hirschfield) 1943. 18s. Seventh Edition.  
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 Underwood, Et A. *A Manual of Tuberculosis*. (Livingstone) 1937. 8s. 6d.  
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### Local Government and the Social Services

- Adams, T. *Outline of Town and City Planning*. (Churchill) 1935. 21s.  
 Blackshaw, W. *The Community and Social Service*. (Pitman) 1939. 7s. 6d.  
 Bruno, Frank T. *The Theory of Social Work*. (Harrap) 12s. 6d.  
 Cadbury Committee. *When We Build Again*. (Allen & Unwin) 1941. 8s. 6d.  
 Calder, R. *The Lesson of London*. (Secker & Warburg) 1944. 2s.  
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- Thomson, G. H. *Instinct, Intelligence and Character*. (Allen & Unwin) 1932. 10s. 6d.
- Walker, Kenneth. *Human Physiology*. (Penguin Books) 1945. 9d. New Edition ; *The Physiology of Sex*. (Penguin Books) 1945. 9d. New Edition.
- Wayman, A. R. *Philosophy of Physical Education*. (Saunders) 1938. 12s.
- Williams, J. F. *Principles of Physical Education*. (Saunders) 1942. 15s.
- Williams, J. F. and Morrison, W. R. *Textbook of Physical Education*. (Saunders) 1939. 14s.
- Williams, J. F., Dambach, J. I. and Schwendener, N. *Methods in Physical Education*. (Saunders) 1937. 12s. 6d.



### **Publications of H.M. Stationery Office**

- Ministry of Education. *Community Centres*. 1944. 9d.; *Suggestions in Health Education*. 1940. 1s.
- Ministry of Health. *Ministry of Health Summary Report for 1943-4*. (Command 6562) 1944. 1s.; *Care of the Homeless*. 1944. 9d.; *Report of the Inter-departmental Committee on Medical Schools*. 1944. 4s. 6d.
- Ministry of Health and Department of Health for Scotland. *A National Health Service*. (Command 6502) 1944. 1s.; *A National Health Service: The Proposals in Brief*. 1944. 3d.
- Ministry of Health and Ministry of Works. *Temporary Accommodation: Memorandum for the Guidance of Local Authorities*, November, 1944.
- Ministry of Health, Ministry of Agriculture and Fisheries and Department of Health for Scotland. *A National Water Policy*. (Command 6515) 1944. 6d.
- Department of Health for Scotland. *Department of Health for Scotland Summary Report for Year ended June 30th, 1944*. (Command 6545) 1944. 4d.
- Ministry of Labour and National Service. *Annual Report of H.M. Chief Inspector of Factories for 1943*. (Command 6563) 1944. 1s. Office of the Minister of Reconstruction. *Employment Policy*. (Command 6527) 1944. 6d.; *Social Insurance. Part I*. (Command 6550) 1944. 6d.; *Part II. Workmen's Compensation*. (Command 6551) 1944. 3d.; *Brief Guide*. 1944. 3d.
- UNRRA. *Agreement for United Nations Relief and Rehabilitation Administration*. 2d.; *White Paper on Resolutions and Reports Adopted by the Council of UNRRA at Atlantic City*, November, 1943. 2s. 6d.; *Report of the Director-General to the Second Session of the Council at Montreal*, September, 1944. Part I, 2s. 6d.; Part II, 1s.; *Helping People to Help Themselves: The Story of UNRRA*. 4d.
- Various Departments. *Report of the Departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*. (Command 6415) 1943. 9d.

### **Publications of the British Medical Association**

- Report of Committee on Nutrition*. 1933.
- Report of Committee on Medical Education*. 1934.
- National Maternity Scheme for England and Wales*. 1934.
- Report of Committee on Fractures*. 1935.
- Report of Committee on Physical Education*. 1936.
- Memorandum on Public Medical Services*. 1937.
- General Medical Service for the Nation*. 1938.
- Memorandum on the Establishment and Development of Provident Associations for Persons of Moderate Incomes*. 1938.
- Memorandum of Evidence submitted to the Royal Commission on Workmen's Compensation*. 1940.
- Draft Interim Report of the Medical Planning Commission*. 1942.
- Memorandum of Evidence to the Inter-departmental Committee on Medical Schools*, 1943.
- Summary of decisions of Annual Representative Meeting on a National Health Service*. 1944.
- Your Doctor and the State*. 1945.

**Publications of the Medical Research Council**

Published by H.M. Stationery Office.

**Special Report Series**

- No. 248. *A Classification of Diseases and Injuries for use in compiling Morbidity Statistics.* Committee on Hospital Morbidity Statistics. 1944. 3s.  
 No. 249. *Studies of Burns and Scalds.* L. Colebrook and Others. 1945. 4s.  
 No. 251. *Mass Miniature Radiography of Civilians.* K. C. Clark and Others. 1945. 3s.

**War Memoranda**

- No. 1. *The Treatment of "Wound Shock."* 1944. 6d. Revised Edition.  
 No. 3. *Economy in the Use of Drugs in War-time.* 1944. 3d. Revised Edition.  
 No. 11. *The Control of Cross-Infection in Hospitals.* 1944. 3d.  
 No. 12. *The Use of Penicillin in Treating War Wounds.* 1944. 3d.  
 No. 13. *Arterial injuries—Early Diagnosis and Treatment.* 1944. 4d.

**Reports of the Industrial Health Research Board**

- No. 85. *The recording of Sickness Absence in Industry.* Sub-Committee of the Board. 1944. 4d.  
 No. 86. *A Study of Certified Sickness absence among Women in Industry.* S. Wyatt. 1945. 9d.  
 No. 87. *The Relation between Illumination and Visual Efficiency—The effect of Brightness Contrast.* H. C. Weston. 1945. 9d.

**Emergency Reports**

- No. 5. *A Study of Variations in Output.* S. Wyatt. 1944. 4d.

**Conditions for Industrial Health and Efficiency**

- No. 2. *Absence from work: Prevention of Fatigue.* 1944. 3d.  
*Health Research in Industry.* Proceedings of a Conference on Industrial Health Research held at the London School of Hygiene and Tropical Medicine, 28th September, 1944. 1945. 6d.

**Publications of the Industrial Welfare Society**

- Welfare in Industry.* 1942. 1s. 6d.  
*Outline of Industrial Welfare and Personnel Management.* 1943. 1s.  
*Health Services in Industry.* 1942. 2s. 6d.  
*Canteens in Industry.* 1942. 2s. 6d. Fifth Edition.  
*Practical Canteen Catering.* 1940. 2s.  
*Superannuation Schemes.* 1935. 2s. 6d.

# Periodicals

**Child Health and Welfare**

- Child Education*, Montague House, Russell Square, London, W.C.1.  
 Monthly, 1s. 3d., annual subscription 16s. 6d.  
*Child Education Quarterly*, Montague House, Russell Square, London, W.C.1.  
 Quarterly, 1s. 3d., annual subscription 6s.

*Journal of Physical Education and School Hygiene*, Hamilton House, Bidborough Street, London, W.C.1. Three issues per annum, 1s. 8d., annual subscription 5s.

*Mother and Child*, National Health Journal, Ltd., 29, Gordon Square, London, W.C.1. Monthly, 1s., annual subscription 10s. 6d.

*Nursery Journal*, 92, Fleet Street, London, E.C.4. Monthly, 3d., annual subscription 3s.

*World's Children*, 20, Gordon Square, London, W.C.1. Monthly, 6d., annual subscription 7s.

### **Eugenics**

*Eugenics Review*, Macmillan & Co., Ltd., St. Martin's Street, London, W.C.2. Quarterly, 3s., annual subscription 12s.

### **Food and Nutrition**

*Food and Cookery Review*, 110, Victoria Street, London, S.W.1. Monthly, 8d., annual subscription 8s.

*Food Research*, H. K. Lewis & Co., Ltd., 136, Gower Street, London, W.C.1. Alternate months, 4s., annual subscription 24s.

*Good Housekeeping*, 28-30, Grosvenor Gardens, London, S.W.1. Monthly, 1s. 6d., annual subscription 21s.

*Journal of Nutrition*, Baillière, Tindall & Cox, 7, Henrietta Street, London, W.C.2. Monthly, annual subscription 63s.

### **Local Government**

*County Council Association Official Gazette*, 84, Eccleston Square, London, S.W.1. Monthly, 6d., annual subscription 8s.

*Local Government Journal*, 1, Norwich Street, London, E.C.4. Monthly, 4d., annual subscription 5s.

*Local Government Service*, National Association of Local Government Officers, 24, Abingdon Street, London, S.W.1. Monthly, 3d., annual subscription 4s.

### **Medicine**

*Annals of the Rheumatic Diseases*, B.M.A. House, Tavistock Square, London, W.C.1. Quarterly, 7s. 6d., annual subscription 25s., members 20s.

*British Journal of Industrial Medicine*, Tavistock Square, London, W.C.1. Quarterly, 7s. 6d., annual subscription 25s., members 20s.

*British Journal of Physical Medicine*, 4-6, Bell Yard, Temple Bar, London, W.C.2. Alternate months, annual subscription 21s.

*British Medical Journal*, B.M.A. House, Tavistock Square, London, W.C.2. Weekly, 1s. 6d., annual subscription 63s.

*British Red Cross Quarterly Review*, 14, Grosvenor Crescent, London, S.W.1. Quarterly, 7d., annual subscription 3s.

*Hospital*, 12, Grosvenor Crescent, London, S.W.1. Monthly, 1s. 3d., annual subscription 15s.

*Journal of Hygiene*, Cambridge University Press, 200, Euston Road, London, N.W.1. Irregular, 16s., 75s. per vol.

*Journal of Industrial Hygiene*, Baillière, Tindall & Cox, 7, Henrietta Street, London, W.C.2. 10 issues per annum, annual subscription 36s.

*Journal of the Chartered Society of Physiotherapy*, Tavistock House (North), Tavistock Square, London, W.C.1. Monthly, 7d., annual subscription 5s.

*Journal of the Royal Institute of Public Health and Hygiene*, 28, Portland Place, London, W.1. Monthly, 2s., annual subscription 24s.

*Journal of the Royal Sanitary Institute*, 90, Buckingham Palace Road, London, S.W.1. Quarterly, 4s., annual subscription 15s.

*Medical Officer*, 72-78, Fleet Street, London, E.C.4. Weekly, 1s., annual subscription 52s. 6d.

*Medical Press and Circular*, Baillière, Tindall & Cox, 7, Henrietta Street, London, W.C.2. Weekly, 6d., annual subscription 27s. 6d.

*Medical Women's Federation Quarterly Review*, 73, Bourne Way, Hayes, Bromley, Kent. Quarterly, private circulation.

*Medical World*, Medical Practitioners' Union, 56, Russell Square, London, W.C.1. Weekly, 1s., annual subscription 42s.

*Medicine To-day and To-Morrow*, 176, Kew Road, Richmond, Surrey. Quarterly, 6d., annual subscription 2s. 6d.

*Occupational Therapy and Rehabilitation*, Baillière, Tindall & Cox, 7, Henrietta Street, London, W.C.2. Alternate months, annual subscription 30s. 6d.

*Postgraduate Medical Journal*, Fellowship of Postgraduate Medicine, 1, Wimpole Street, London, W.1. Monthly, 2s., annual subscription 24s.

*Practitioner*, 5, Bentinck Street, London, W.1. Monthly, 4s., annual subscription 42s.

*Prescriber*, 3, Howe Street, Edinburgh. Monthly, 2s., annual subscription 21s.

*Proceedings of the Royal Society of Medicine*, 43, Albert Drive, London, S.W.19. Monthly, 7s. 6d., annual subscription 105s.

*Public Health*, Society of Medical Officers of Health, Tavistock House (South), Tavistock Square, London, W.C.1. Monthly, 2s. 6d., annual subscription 31s. 6d.

### Nursing

*First Aid*, 46, Cannon Street, London, E.C.4. Monthly, 3d., annual subscription 4s.

*Hospital and Nursing Home Management*, Trafalgar Press, Ltd., Cressfield, Ecclefechan, Lockerbie, Dumfriesshire. Monthly, 1s., annual subscription 12s.

*Midwives' Chronicle and Nursing Notes*, 57, Lower Belgrave Street, London, S.W.1. Monthly, 6d., annual subscription 7s.

*Nursing Mirror and Midwives' Journal*, Dorset House, Stamford Street, London, S.E.1. Weekly, 4d., annual subscription 26s.

*Nursing Times*, Macmillan & Co., Ltd., St. Martin's Street, London, W.C.2. Weekly, 3d., annual subscription 19s. 6d.

*Queen's Nurses Magazine*, 10, Sydney Street, London, S.W.3. Monthly, 5d., annual subscription 5s.

### Psychology

*British Journal of Psychology*, Cambridge University Press, 200, Euston Road, London, N.W.1. Three issues per annum, annual subscription 30s.

*Journal of Mental Science*, 104, Gloucester Place, Portman Square, London, W.1. Quarterly, 10s. 6d., annual subscription 42s.

*Mental Health*, Provisional National Council for Mental Health, 39, Queen Anne Street, London, W.1. Three issues per annum, 1s., annual subscription 3s. 6d.

*Occupational Psychology*, National Institute of Industrial Psychology, Aldwych House, London, W.C.2. Quarterly, 5s., annual subscription 20s.

### Social Services and Welfare

*Annual Charities Register and Digest*, Charity Organisation Society, Denison House, Vauxhall Bridge Road, London, S.W.1. Annually, 10s. 6d.

*How to Help Cases of Distress*, Charity Organisation Society, Denison House, Vauxhall Bridge Road, London, S.W.1. Annually, 4s. 6d.

*Quiet*, Noise Abatement League, 105, Gower Street, London, W.C.1. Quarterly, 1s., annual subscription 10s. 6d.

*Sanitarian*, Sanitary Inspectors' Association, 19, Grosvenor Place, London, S.W.1. Monthly, 1s., annual subscription 14s.

*Social Work*, Charity Organisation Society, Denison House, Vauxhall Bridge Road, London, S.W.1. Quarterly, 1s., annual subscription 4s.

*Sociological Review*, Le Play House Press, Albert Road, Malvern, Worcs. Bi-annually, 10s. 6d., annual subscription 21s.

*Industrial Welfare and Personnel Management*, Industrial Welfare Society, 14, Hobart Place, London, S.W.1. Alternate months, 2s., Annual Subscription, 12s.

## Films

THIS list of documentary films has been prepared by the British Film Institute of 4, Great Russell Street, London, W.C.1. Further information regarding any of them may be obtained on application to the Institute. Enquiries about bookings should, however, be addressed to the distributors concerned, a list of whom is given at the end of this Section.

<i>Title</i>	<i>Length</i>	<i>Size</i>	<i>Sound (Sd.), Silent (St.) or Mute (no Captions)</i>	<i>Distributors</i>	
<b>HEALTH EDUCATION.</b>					
<b>The Reproductive System.</b>	(A series of 5 "Human Body" films)	12 mins.	16 mm.	St.	J. G. Kirkham
<b>Arteries and Blood Circulation.</b>		12 mins.	16 mm.	St.	J. G. Kirkham
<b>The Heart</b> .. .. .		12 mins.	16 mm.	St.	J. G. Kirkham
<b>The Respiratory System</b>		12 mins.	16 mm.	St.	J. G. Kirkham
<b>The Digestive Track ..</b>		12 mins.	16 mm.	St.	J. G. Kirkham
<b>A Start in Life</b> (Health Services for children).	22 mins.	35 mm.	Sd.	C.F.L.	
<b>National Health</b> (How Britain safeguards her people's health).	11 mins.	16 mm.	Sd.	Gebescope	
<b>Student Nurse</b> (Training of State-Registered Nurses).	37 mins.	16 mm.	Sd.	Gebescope	
<b>Hawkmoor Nurse</b> (Work of nurses in Devon County Sanatorium, Bovey Tracey).	18 mins.	16 mm.	St.	D.H.F.U.	

Title	Length	Size	Sound (Sd.), Silent (St.) or Mute (no Captions)	Distributors
<b>Conquest of a Germ</b> (A tribute to the research workers and doctors who discovered the sulphonamide drugs).	16 mins.	16 mm. 35 mm.	Sd.	C.F.L.
<b>Round Figures</b> (Central Council for Health Education on the importance to health of standing and walking correctly).	9 mins.	16 mm. 35 mm.	Sd.	C.F.L.
<b>A Flying Start</b> (Central Council for Health Education on breast feeding for children).	12 mins.	16 mm. 35 mm.	Sd.	C.F.L.
<b>Children Must Laugh</b> (A story of a pre-war experiment in medical and social treatment of under-nourished tubercular children from Warsaw).	31 mins.	16 mm. 35 mm.	Sd.	C.F.L.
<b>Highland Doctor.</b> (The Highlands and Islands Medical Service in Scotland.)	21 mins.	16 mm. 35 mm.	Sd.	C.F.L.
<i>B.F.I. Bulletin Reference</i>				
<b>Breathing</b> (Elementary physiology of breathing).	10 mins.	I. p. 46	Mute and Sd.	Gebescope
<b>Circulation</b> (Structure and function of the human circulatory system).	10 mins.	VII. p. 14	Mute and Sd.	Gebescope
<b>Muscles</b> (Structure) .. .. .	17 mins.	VII. p. 14	St.	Kodak
<b>Body Framework</b> .. .. .	17 mins.	VII. p. 13	St.	Kodak
<b>Blood</b> .. .. .	15 mins.	VII. p. 13	St.	Kodak
<b>Circulation</b> .. .. .	17 mins.	VII. p. 14	St.	Kodak
<b>Breathing</b> .. .. .	18 mins.	—	St.	Kodak
<b>The Red Army</b> (Propaganda film for extermination of the Bed Bug).	10 mins.	III. p. 94	Mute and Sd.	Gebescope
<b>The Filter</b> (Shows the microscopic creatures which are found in water, together with methods of filtration, etc.).	10 mins.	II. p. 19	Mute and Sd.	Gebescope
<b>Vision</b> (Structure of the eye, correction and relief given by correct glasses).	10 mins.	IV. p. 118	Mute and Sd.	Gebescope
<b>Enough to Eat</b> (Surveys inadequate food budgets among large numbers of people: suggests ways and means to good diet).	20 mins.	III. p. 187	Sd.	C.F.L.
<b>Green Food for Health</b> (Green Vegetables).	6 mins.	—	Sd.	C.F.L.
<b>White Battle Front</b> (Army medical services and their fight to prevent diseases and care of the wounded).	10 mins.	VIII. p. 111	Sd.	C.F.L.
<b>Nurse</b> (Work done by women in all branches of nursing).	9 mins.	VIII. p. 111	Sd.	C.F.L.
<b>Health in War</b> (Exposition of the plans in operation on the outbreak of war to care for raid casualties and plans to improve the health services).	13 mins.	VIII. p. 111	Sd.	C.F.L.
<b>Mother and Child</b> (Maternity and child welfare services).	10 mins.	VIII. p. 111	Sd.	C.F.L.
<b>Britain's Youth</b> (Talk by C. B. Fry on the value of games).	13 mins.	—	Sd.	C.F.L.

Title	Length	Sound (Sd.), B.F.I. Silent (St.) Bulletin or Mute Reference (no Captions)		Distributors
<b>Fitness for Service</b> (Exercises and games maintain fitness).	9 mins.	—	Sd.	C.F.L.
<b>On Whiskers</b> (made to teach children under 10 the importance of cleanliness and the eating of good food).	10 mins.	—	Sd.	C.F.L.
<b>Carry on, Children</b> (Health services for children from birth to adolescence).	11 mins.	IX. p. 10	Sd.	C.F.L.
<b>Out and About</b> (Walking at week-ends and staying at Youth Hostels).	9 mins.	—	Sd.	C.F.L.
<b>Action</b> (Games provide training and exercise for character-forming in wartime).	9 mins.	—	Sd.	C.F.L.
<b>Defeat Diphtheria</b> (Immunisation) ..	12 mins.	X. p. 109	Sd.	C.F.L.
<b>Breath of Danger</b> (Protection from the common cold).	9 mins.	IX. p. 10	Sd.	C.F.L.
<b>Victory Over Darkness</b> (Work done at St. Dunstan's in looking after the Blind).	6 mins.	—	Sd.	C.F.L.
<b>ABCD of Health</b> (Simple exposition of the four vitamins A, B, C, D, etc.).	9 mins.	—	Sd.	C.F.L.
<b>Dinner at School</b> (Provision of a good meal at mid-day).	10 mins.	—	Sd.	C.F.L.
<b>For Children Only</b> (An appeal to mothers to take full advantage of the schemes for providing children with fruit juices, etc.).	7 mins.	—	Sd.	C.F.L.
<b>Rat Destruction</b> (Methods by which local Rodent Officers track down and destroy rats).	10 mins.	—	Sd.	C.F.L.
<b>No Accidents</b> (Accident risks in factories and how they can be prevented).	10 mins.	—	Sd.	C.F.L.
<b>Tuberculosis</b> (How it is contracted and may be avoided, etc.).	11 mins.	X. p. 109	Sd.	C.F.L.
<b>The Nose Has It</b> (Arthur Askey on how to sneeze).	8 mins.	—	Sd.	C.F.L.
<b>Of One Blood</b> —Blood Transfusion Service.	15 mins.	—	Sd.	C.F.L.
<b>Blood Transfusion</b> (Short version for the public, long version for the medical profession).	21 mins.	X. p. 118	Sd.	C.F.L.
<b>Scabies</b> —The large rise in scabies just before and during the war, diagnosis and treatment of this disease are shown by micro-photography and diagrams.	36 mins.	X. p. 96	Sd.	C.F.L.
<b>Scabies Mite</b> (An instructional film for specialists and students showing in detail, by means of photo-micrography and diagrams the life cycle of the Sarcopites).	7 mins.	—	Sd.	C.F.L.
<b>Subject for Discussion</b> (The film approaches the subject of venereal disease in a fair way, showing the importance of early treatment and pleading for frank public discussion on the subject).	15 mins.	—	Sd.	C.F.L.

Title	Length	Sound (Sd.), B.F.I. Silent (St.) Bulletin or Mute Reference (no Captions)		Distributors
<b>Neuro Psychiatry</b> . . . . .	68 mins.	—	Sd.	C.F.L.
<b>Mass Radiography</b> ( <i>x-ray Mobile</i> Units for detecting tuberculosis).	10 mins.	—	Sd.	C.F.L.
<b>Outposts of Health</b> (Diagrammatic film dealing with care of the teeth).	23 mins.	I. p. 63	St.	D.B.
<b>Two Little Pigs</b> (Humorous cartoon about teeth).	8 mins.	—	St.	D.B.
<b>The Leaflet</b> (Care of an expectant mother's teeth).	15 mins.	—	St.	D.B.
<b>The Trapeze Man Talks</b> (Behind the scenes at a circus, why the strong man is able to lift weights with his teeth).	18 mins.	—	St.	D.B.
<b>Practice Makes Perfect</b> (This theme is illustrated by pictures of experts in various aspects of sport and work and then leads to care of the teeth).	15 mins.	VII. p. 104	Sd. St.	D.B.
<b>Nature Shows the Way</b> (How teeth may be preserved by correct diet and care as they are in the animal world).	19 mins.	VII. p. 82	Sd. St.	D.B.
<b>Fear and Peter Brown</b> (An under- standing of fear leads to the beginning of courage).	15 mins.	VII. p. 124	Sd.	C.C.H.E.
<b>Breath of Danger</b> ( <i>See</i> description under C.F.L.).	9 mins.	IX. p. 10	Sd.	C.C.H.E.
<b>Carry On, Children</b> (Also in C.F.L.).	12 mins.	IX. p. 10	Sd.	C.C.H.E.
<b>Fine Feathers</b> (Jeanne de Casalis in a talk on a sound diet).	12 mins.	IX. p. 11	Sd.	C.C.H.E.
<b>Skin Deep</b> (Film in colour on cleanli- ness of the body).	17 mins.	IX. p. 11	Sd.	C.C.H.E.
<b>Footsteps to Beauty</b> (Care of the feet)	10 mins.	IX. p. 11	Sd.	C.C.H.E.
<b>Choose to Live</b> (Story of an American home in which the mother suspects she may have cancer. She sees her doctor and through treatment is cured).	—	—	Sd.	C.C.H.E.
<b>Uncle Timothy's Tea Party</b> (A taxi- dermist gives a tea-party for a few of the children living in his village, he takes the opportunity to impress on their minds a few simple facts about personal hygiene and cleanliness).	6 mins.	XII. p. 26	Sd.	C.C.H.E.
<b>The Unwelcome Guest</b> (This film deals with the head louse and the method of treatment).	11 mins.	—	Sd.	C.C.H.E.
<b>Young and Healthy</b> (Health hints in the form of a fantasy).	11 mins.	X. p. 58	Sd.	C.C.H.E.
<b>Sex in Life</b> (Part I Biology of Sex) . .	25 mins.	V. p. 229	Sd.	C.C.H.E.
<b>Sex in Life</b> (Part II Human repro- duction).	—	—	—	—
<b>Road to Health</b> (Cartoon film repre- senting the road to health and the by- roads, from it, <i>e.g.</i> , immorality, pros- titution, etc., which if followed, lead into the bog of venereal disease).	12 mins.	V. p. 229	Sd.	C.C.H.E.
<b>Other Films</b> dealing with Social Hygiene are also available from :	—	—	St.	B.S.H.C.



<i>Title</i>	<i>Length</i>	<i>B.F.I. Bulletin Reference</i>	<i>Sound (Sd.), Silent (St.) or Mute (no Captions)</i>	<i>Distributors</i>
<b>Cartoons and Episodic Films on Cleanliness from :</b>	—	—	Sd. and St.	H. & C.C.
<b>Films on Maternity and Child Welfare</b> available from :	—	—	St.	N.C.M.C.W.
<b>A Drink of Water</b> (When it should appear in the daily schedule).	10 mins.	—	St.	W. Heaton
<b>Cleanliness.</b> Clean Clothes, Clean Face and Hands. (Elementary).	10 mins.	—	St.	W. Heaton
<b>Food, Digestion and Air</b> (Processes of digestion, animated diagrams).	12 mins.	—	St.	F.E.
<b>Stand Up and Breathe</b> (What fresh air means in work and sport).	19 mins.	II. p. 159	Sd.	N.A.P.T.
<b>A New Beginning</b> (Rehabilitation for those who have had T.B.).	11 mins.	XII. p. 26	Sd.	N.A.P.T.
<b>Other Films</b> also available . . . .	—	—	—	N.A.P.T.
<b>The House Fly</b> (Life history and the reasons why it is a menace to health). (American).	15 mins.	V. p. 93	St.	W. Heaton
<b>Smoke Menace</b> (Story of a campaign for a cleaner atmosphere).	14 mins.	V. p. 214	Sd.	B.C.G.A.
<b>Road Safety</b> (Films on this subject are available from :	—	—	—	R.S.P.A.
<b>Cleanliness</b> (Keeping the hair clean—bathing). (Elementary)	10 mins.	—	St.	W. Heaton
<b>War Without End</b> (Record of the wonderful achievements of medical science and of the work of our hospitals today).	30 mins.	V. p. 147	Sd.	C.F.L.

### PHYSICAL EDUCATION AND "KEEP FIT"

<b>Children, aged 4-6</b> ..	A series of twelve films produced in collaboration with the Physical Education Committee of the British Film Institute and based on the Board of Education Syllabus of Physical Training for Schools (1933).	13 mins.	II.	Mute	G.B.E.
<b>Children, aged 7</b> ..		10 mins.	p. 183 V.	and Sd. Mute	C.B.E.
<b>Rural School :</b>			p. 229	and Sd.	
<b>Children 8-11</b> .. ..		11 mins.	III.	Mute	G.B.E.
<b>Boys, aged 10</b> .. ..		10 mins.	p. 94 IV.	and Sd. Mute	G.B.E.
<b>Girls, aged 11</b> .. ..		19 mins.	p. 116 II.	and Sd. Mute	G.B.E.
<b>Progressive Training in Ball Handling</b>		12 mins.	p. 184 III.	and Sd. Mute	G.B.E.
<b>Boys' Summer Playing Field Activities</b>		12 mins.	p. 58 IV.	and Sd. Mute	G.B.E.
<b>Boys' Winter Games</b>		12 mins.	p. 117 IV.	and Sd. Mute	G.B.E.
<b>Girls' Winter and Summer Playing Field Games</b>		10 mins.	p. 117 IV.	and Sd. Mute	G.B.E.
<b>Analysis of Exercises Performed with a Rhythmic Swing</b>		10 mins.	p. 5 III.	and Sd. Mute	G.B.E.
<b>Analysis of Agility Exercises</b>		12 mins.	p. 57 IV.	and Sd. Mute	G.B.E.
<b>Carriage</b> .. ..		11 mins.	p. 5 III.	and Sd. Mute	G.B.E.

Title	Length	Sound (Sd.), B.F.I. Silent (St.) Bulletin or Mute Reference (no Captions)		Distributors
<b>Pennies for Health</b> (Improving Physical Fitness by joining organisations).	10 mins.	V. p. 231	Sd.	G.B.E.
<b>Our Normal Day</b> (How the average working man and woman can cultivate vital strength by organised physical education).	11 mins.	V. p. 231	Sd.	G.B.E.
<b>Daily Dozen</b> (Exercises which can be performed in the bedroom; taken from the pamphlets of the Central Council of Recreative Physical Education).	12 mins.	V. p. 230	Sd.	G.B.E.
<b>The Road to Records</b> (Home exercises based on the movements of certain sports).	11 mins.	V. p. 231	Sd.	G.B.E.
<b>Family Fitness</b> (Correction of bodily faults caused by school work, office work and house work).	11 mins.	V. p. 230	Sd.	G.B.E.
<b>Healthy Holidays</b> (How to make the most of holidays).	11 mins.	V. p. 230	Sd.	G.B.E.
<i>The "Strength and Beauty" Series, demonstrating simple exercises for the average man and woman.</i>				
<b>MEN.</b>				
<b>Beginners Please</b> (Elementary stages recreative exercises).	10 mins.	—	Sd.	G.B.E.
<b>Twenty Men and a Leader</b> (Advanced recreative exercises).	10 mins.	—	Sd.	G.B.E.
<b>Five Fit Fellows</b> (Vaulting and agility exercises).	10 mins.	—	Sd.	G.B.E.
<b>Fitness Wins the Game</b> (Games and athletics).	10 mins.	—	Sd.	G.B.E.
<i>"Fitness Wins" Series.</i>				
<b>WOMEN.</b>				
<b>Four-and-Twenty Fit Girls</b> (A class in recreative exercise).	10 mins.	—	Sd.	G.B.E.
<b>Eighteen Girls and a Horse</b> (Vaulting, and how to "receive").	10 mins.	—	Sd.	G.B.E.
<b>Fresh Fields</b> (Walking and camping).	10 mins.	—	Sd.	G.B.E.
<b>Invitation to the Dance</b> (Modern Dance).	10 mins.	—	Sd.	G.B.E.
<b>Physical Training for Senior Boys</b> (Physical exercises in the gymnasium, such as "hamstring stretching," spanning, abdominal and lateral exercises, marching, rope-climbing and group activities such as balancing, vaulting, beam circling and a ball game).	16 mins.	X. p. 119	St.	E.G.S.
<b>How Do You Get Your Exercise?</b> (Miscellaneous methods from baseball to gymnastics, with sequence on firemen's drill).	15 mins.	IV. p. 207	St.	W. Heaton
<b>Recreative Exercises for Mothers and Toddlers at a Welfare Centre.</b>	20 mins.	IV. p. 207	St.	N.C.M.C.W.

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## Recent Amendments to Social Security Act

See Health and Social Welfare in New Zealand—Lorna C. M. McPhee, B.A., page 168.

In the Budget presented to Parliament in New Zealand on August 9 considerable changes in the rates of benefit payable under the Social Security Act were announced. As from the 6th October, 1945, age benefits are increased to £2 per week, with comparable increases in widows', miners', sickness, unemployment, and war veterans' allowances. A minimum family income on the basis of a family of two children is provided for at the rate of £5 per week during sickness and unemployment or invalidity (£2 per week for father and mother and 10s. a week for each child.) It was also announced by the Minister of Finance, Mr. Walter Nash, that legislation is to be promoted to provide minimum wages for all workers, male and female. To some extent this is already provided for by the Arbitration Court awards and Agricultural Workers Act and the general order concerning minimum basic wages promulgated by the Arbitration Court under the authority of the Industrial Conciliation and Arbitration Act, 1936.

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